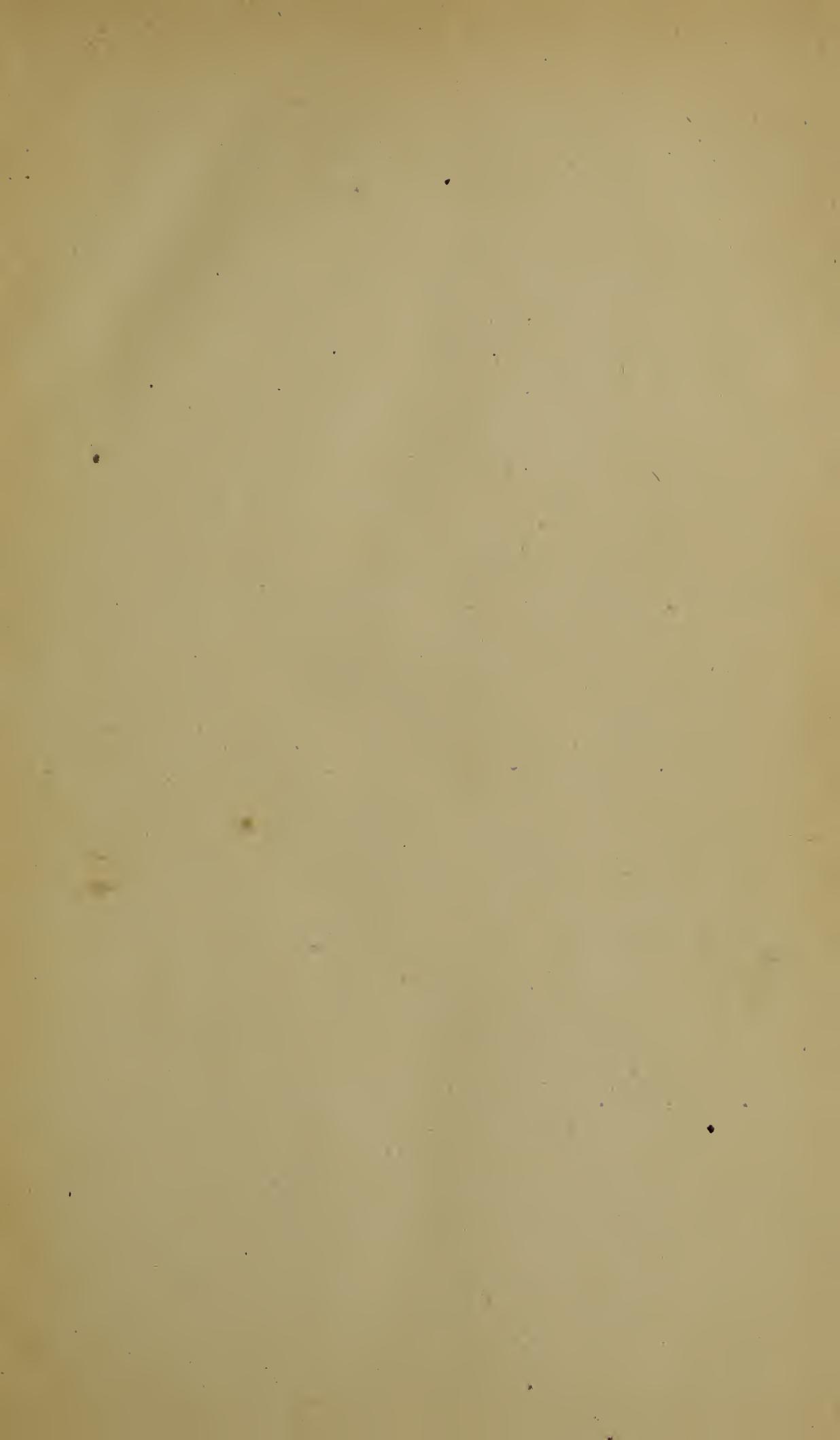


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THE JOURNAL OF MENTAL PATHOLOGY.

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No. 1.

DEFINITION OF PROGRESSIVE PARALYSIS; ITS DIFFERENTIATION FROM SIMILAR FORMS OF DISEASE

AUG 29 1917

Professor VLADIMIR TSCHISCH,
University of Dorpat, Russia

The various definitions of general paralysis, Winswenger's among others (1), have proven inadequate, because the methods which led up to the forming of these definitions are wrong. From a theoretical standpoint, this imperfection in definition is perhaps of small importance; particularly is this the case to-day, when facts outweigh ideas; practically, however, it is of the utmost importance to have a proper definition of this disease, as it is necessary to know how to differentiate it from other diseases, which resemble it in form.

The difficulty in making an accurate diagnosis in these cases is far greater than is supposed at first sight. I need only state here that equally reputable physicians are very apt to make different diagnoses of one and the same case, where the pathological signs are not quite definite: one physician may diagnose such a case as being one of general paralysis, while another may diagnose it as being dementia due to organic cerebral lues. Indeed, it is a matter of frequent occurrence to find, for instance, some physicians considering a given case as being one of general paralysis with focal lesions, while another, quite as capable a physician, declares that the same case is not one of general paralysis; one finds, similarly, cases described by some as being general paralysis with hallucinations, while others doubt the possibility of the very existence of hallucinations in these cases.

It is quite evident that the cause of such divergences of opinion must depend not on an insufficiency of medical accomplishment, but simply on an inexact method of reasoning. For the reason roughly outlined above, it becomes of great importance to have some uniform definition of progressive general paralysis. It was somewhat difficult to fix on a uniform definition of general paralysis when it was held that numerous causes entered into its etiology. According to Muensterberg (2), all identical manifestation de-

pends on identity of causation. As various causes (syphilis, over-work, etc.) were admitted to be at the root of one disease—general paralysis, one should not be astonished to find, as a result, such a marked confusion of diagnoses.

Even if we admitted that only one cause,—syphilis, was to be considered in connection with the birth of general paralysis, it were difficult to properly define the disease; for, we know that not all syphilitic subjects are general paralytics. It is evident that syphilis alone is not the causative agent of the disease; on the contrary, it must be some condition connected with, or accompanying syphilis, that causes the affection to manifest itself. In some respects, an acceptable definition of the disease might be formulated, on the ground that a complexus of causes (syphilis, heredity and alcoholism) determine general paralysis. Such a definition would, however, be quite contradictory to existing facts. Indeed, we know of cases of general paralysis in subjects who had never indulged in alcoholic excesses nor have they any pathological heredity. On the other hand, we have all met with cases,—neuro-paths, who were syphilitics, who indulged in alcoholic excesses and who did not show any manifestations of general paralysis. From these examples it is quite evident that we have no particular reason to incriminate some morbid agent as being the cause of general paralysis, when we find that at times that cause does, while at others it does not, precede the onset of general paralysis. The condition that would make it legitimate to fix on a given morbid agent as being an infallible cause of general paralysis would be if that morbid agent always preceded the onset of general paralysis. It is also erroneous to maintain that syphilis, insufficiently treated, leads to the manifestation of general paralysis.

In my work on general paralysis (4) I express the practical idea that the disease is a specially malignant form of syphilis.

A close comparison of the various symptoms of syphilitic diseases of the nervous system brings out the fact that general paralysis is characterized by a distinctive trait which differentiates the disease from other forms of late syphilis.

Indeed, in general paralysis, syphilis seems to affect every tissue in the body. Therefore, we must look on the clinical character of general paralysis as on a disease in which the whole organism becomes involved in the morbid process. We are all familiar with the fact that not one organ, not one given tissue, is spared in the morbid process evolving during the course of this disease.

In all other forms of syphilis than that which I call general paralysis, the syphilitic poison seems to remain in one or more

focuses: this or that tissue may be involved preferably, or one or more groups of tissues may become the seats of morbid development, while numerous tissues in the same organism remain intact. We are familiar with the manifestations as I describe them, in tertiary syphilis. Consider, for example, syphilis of the central nervous system: we may witness here every degree of syphilitic involvement: for instance, diplopia, readily yielding to treatment; such an involvement may be due to a focus, sometimes not larger than a pin's head; these focuses may, on the other hand, be very extensive as well as numerous, and cause symptoms to take place, which may resemble those indicative of general paralysis. When numerous focuses are active, this resemblance may be particularly striking. In fact, the symptomatic appearance may be so similar that even an experienced physician may find difficulty in differentiating between such a case of lues cerebri and general paralysis. In fact, if the patient's mind becomes weakened, the speech disturbed, the joints impaired, and the disease progresses, we are forced to diagnose the case as one of general paralysis. The above cited complexus of symptoms may also be accompanied by focal paralyses (hemiplegia, ataxia, etc.). Such paralyses may sometimes complicate symptoms which have some resemblance to those found in progressive general paralysis, and a diagnosis of the latter disease is also made, although syphilis is entirely absent from the clinical manifestations.

Here, again, we see the great difficulties that attend the true understanding of the nature of the disease and the many hindrances in the matter of adopting prophylactic measures against it.

It is noteworthy that no matter how numerous the syphilitic focuses, central or other, may be, there are always some parts in the organism left unaffected by the disease, when the affection is not accompanied by general paralysis. Even during the last days of life of such syphilitics, we find integrity of some or other functions (speech, memory, etc.); there is not a single case of lues cerebro-spinalis in which the entire organism has undergone destruction. The conditions are different, however, in meta- and para-syphilis, i. e., progressive general paralysis and tabes spinalis.

It is reasonable to suppose that the syphilitic poison acts differently under different circumstances: in some cases it seems to diffuse itself and to penetrate into every living tissue of the organism which it affects, while in others it seems to limit itself to the infection of circumscribed areas.

At present we have no clue to this unaccountable phenomenon of the working of the syphilitic poison. The metamorphosis of the syphilitic poison in various cases is quite as difficult of under-

standing as it is difficult to explain why putrid matter in the organism causes now pyæmia, now septicæmia. Where the syphilitic poison acts as a general infection, we are struck by a noteworthy phenomenon: generally, all tissues are equally affected and it is impossible to say that this or that part of the body has borne the brunt of the disease more than did another.

Progressive general paralysis is characterized by the trait that the syphilitic poison is diffused in all parts of the organism, and it is impossible to find any one part that is more affected by the disease than is another. This general diffusion of the poison has its distinctive and corresponding clinical manifestations in general paralysis: the anatomo-pathological alterations due to the syphilitic poison are diffuse throughout the organism and are remarkable for the indistinctness of their condition, during the first stage of the disease. Even the most expert anatomo-pathologist cannot positively identify these morbid changes in the first stage of general paralysis, when death takes place through an accidental cause. As is well known, and as I have often maintained, no definite microscopic changes can be found in such subjects. The only tangible alterations are the vascular changes, whereas the rest of the tissues do not present anything pathognomonic of this disease at this stage; on the whole, even with the apparent vascular changes, a positive diagnosis of progressive general paralysis cannot be made at an early stage of the affection. The diagnosis rests here on the very indistinctness and indefiniteness of the signs.

On the other hand, microscopic sections obtained from subjects who died of marasmus during the course of general paralysis (5) show that the pathological changes of the organs are universal, involving all the tissues to the same degree: not one organ, not any one tissue is spared by the disease, all being affected in the same manner: the heart, the liver, the intestinal tract, etc., all are uniformly affected. It may be remarked, however, that the least altered organs are the testicles and the most altered tissue is the foremost part of the brain. The bones, the cranium, the blood (6), as seen from examinations, undergo considerable changes, as is well known.

Searching for an explanation of this so-called graded alteration according to the nature of the tissue, it appears that the tissues that develop latest are affected first and more markedly. At least, we are forced to accept this solution of the problem, if we are to be guided by the comparative alterations found in the hind brain and the fore-brain of the same paralytic subject. The early affection of the mind in this disease is easily explained by the early affection of the forebrain.

To the psychiatrist is due the honor of having discovered the essential phenomena of progressive paralysis, because the mind is first affected in this disease, characterized by the involvement of the entire system; the affection of the other organs is of secondary consideration, and, therefore, the disease escaped the scrutiny of the general practitioner. The disease has, for this reason, been looked on as a purely psychiatric affection (7); even the anatomo-pathologist attaches no particular importance to the alteration of all the other organs than the brain; yet, it is quite evident that during the course of general paralysis many other organs than the brain undergo pathological changes: the bones, the sympathetic nervous system, etc. (8).

It seems unreasonable to crystallize the whole series of the tissues affected in this disease into one narrow limitation by saying that the affection consists of a pathological change of the brain alone; from what we know of the clinical manifestations of the disease this definition is inconsistent. It is incorrect to say that all the rest of the changes are of trophic origin, because this explanation is incomprehensible from a clinical standpoint. It is also incorrect to say that the disease is of purely psychiatric origin. Although this class of patients are the best nursed and generally well cared for, the marasmus which they manifest seems to surpass any known in clinical work. It is not an uncommon occurrence to see these patients lose one-half of their body weight during the fatal course of the disease; all the tissues seem to die away in their substance, unless the patient dies of some intercurrent disease, before all the ravages of the disease have been fully displayed.

Is it possible that such generalized organic destruction, allow me the expression, should depend on a local process,—an affection of the brain only? The admission of this supposition seems to me to be nothing short of nonsense.

When a patient suffers from cerebral syphilis alone, we witness quite a different clinical picture. It is well known that in such cases we generally find one or two gommata in the brain and a generalized arterio-sclerosis; the general condition is passably satisfactory and the internal organs do not show any remarkable alterations.

In patients with other tumors of the brain, similar conditions may be observed, excepting, perhaps the presence of the arterio-sclerosis.

There is, then, a vast difference between the two conditions of lues cerebri,—the local and the eminently diffuse form. The anatomo-pathological pictures of diffuse and circumscribed syphilis are vastly different one from the other. In some instances, we see

that the syphilitic infection has caused the formation of neoplasms, of inflammatory processes, of atrophies and of other degenerations, which are grouped in the tissues without any order or plan. When syphilis thus attacks the individual organs, one or more organs may be attacked at the same time; besides, the patient may suffer from syphilis of the brain and the liver and the lungs at the same time and die from syphilis, not of the brain, but of that of the liver, or of the lungs, etc.

As lues cerebri is characterized by focal lesions, we can find that even in the immediate vicinity of those focuses normal tissue may exist; but in general paralysis these conditions are quite different: here a complete diffusion of the pathological changes dominates the scene.

It is true that in some cases lues cerebri and general paralysis are so closely alike in their appearances that it is quite difficult to distinguish one from the other on the post-mortem table. This may happen when the syphilitic focuses are not numerous, the focal disturbances not important, when the patient had suffered from the disease a long time and when the degenerative processes are predominant. A thorough examination, however, always shows the presence of focuses in cases of lues cerebri; one can also find comparatively healthy parts of the affected organ; these signs are sufficiently helpful in the making of a correct diagnosis. Among other signs are: the presence of old focuses, markedly noticeable scleroses of some vessels as contrasted with slight sclerosis of others and apparently healthy condition of still others. In general paralysis, as we have seen, the uniformity of alteration is the pre-eminent feature.

Progressive general paralysis is a progressive disease in which all the parts of the body are proportionately affected, every function suffering from its involvement. We are thus enabled to exclude the presence of progressive general paralysis when we find a deviation from this clinical picture. There is no other disease in which such a proportionate destruction of all the organs and tissues is observed.

As has been remarked, progressive paralysis is considered as being a cerebral affection because the mental feature of the disease is most marked and it is consequently of most practical value. An experienced psychiatrist can see in this disease, in addition to the mental phenomena, a whole train of other pathological manifestations. Here one finds an impaired process of assimilation involving the most essential functions in the system: There is an impairment in the blood formation, in the heart's action, in the vascular nutrition, the respiration and the muscular activity; the urinary

composition is also changed and the spermatic secretion is altered; indeed, we know that even in patients with exaltation the sexual life is rather weakened. I have valuable information from educated patients who have stated to me that from the very beginning of the disease the sexual appetite had undergone a marked weakening (impaired erection as well as weakened ejaculation). This question of impaired secretions should be more carefully studied than it has been up to now. I have the information from my patients and from their friends that even the salivary secretion suffers from the morbid process,—this secretion becomes less in amount from the very onset of the disease. Observations on patients who are in a habit of spitting considerably (cigar or pipe smokers) are very instructive in this respect, as the diminished amount of the matter spat by them is quite considerable.

Mentally, there is a similar slackening of function; and, besides, there is no disease known to us, in which mental impairment shows itself to such a profound degree in so short a time. This process of psychic destruction is universal,—not one phase of this function being spared in the morbid process. If we turn to the motor and sensory functions, a similar generalized impairment is also observed.

It is of interest to note that the muscular strength is scarcely weakened in general paralysis, and yet muscular movement is noticeably impaired and the co-ordination is uncertain. Although some of the special functions do not undergo early alterations, the speech is early implicated in the course of the disease. In fact, the disturbance of speech is one of the cardinal symptoms of general paralysis. As is currently admitted, the latest acquirements are the first to suffer impairment. As speech is one of the functions latest developed, it is natural for it to disintegrate first in a generalized morbid process of the whole system. The ability to sing, one of the latest acquirements, is the first to suffer during this morbid process; the ability to handle musical instruments, to dance, etc., is also early impaired during the course of general paralysis.

The speech disturbance has been carefully studied in its relation to this disease; it must be remarked, however, that the speech alterations here are not of focal nature. On the contrary, many and complex anatomical conditions enter into play in this pathological process.

Indeed, we know what a great difference there is in the anatomical positions of the right and left carotid arteries. The position of the left artery is such that it furnishes the blood supply to the left brain in a manner far superior to that furnished to the right. We also know that the higher of two similar tissues in the same organ-

ism is the latest developed; *a priori*, the left hemisphere must be the one developed later than is the right one. And I have had occasion to mention that the left carotid artery generally became affected with arterio-sclerosis earlier than did the right one (9); for this reason we are right in supposing that the left hemisphere is affected by the parasyphilitic poison very much earlier than is the right one; this clinical fact explains the reason of the early pathological manifestations of speech during the course of progressive general paralysis.

It is somewhat difficult to demonstrate anatomically these subtle differences at an early stage of the disease; later on, when the affection has progressed to some marked extent, this demonstration is again difficult to make, because the essential characteristic of the disease is generalized diffusion of pathological changes, as I have pointed out. At a late stage of the disease, the disturbance of speech no longer stands out as an ultra-proportionate characteristic compared to all the other morbid manifestations; on the contrary, there exists, then, a correlative involvement of speech and of the other functions, so that not any one of the alterations of function can be said to be more marked than is the other. This generalized and diffuse manifestation of the pathological conditions makes the diagnosis of general paralysis unmistakable.

The psychiatrist can well be guided in the making of the diagnosis of general paralysis by carefully examining some of the psychic signs. Thus, the condition of memory can be a helpful guide. Take, for instance, an engineer, whose psychic and other functions seem to be in perfect condition, but who manifests a loss of memory entirely out of proportion with any other disturbance to which he is subject; when he is in such passable general condition, but cannot remember the name of the street in which he has lived a long while, or in which he lives at the time the examination takes place, the physician is safe in excluding the diagnosis of progressive general paralysis; it is far safer to suppose, under such circumstances, that the subject is suffering from dementia ex luesio organica; if the history reveals the truth of the existence of syphilitic infection in such a subject, general paralysis should at once be excluded from consideration.

A patient who consulted me at the clinic presented a clear case of Lues; he looked in every respect like a general paralytic, but he had hallucinations of hearing. As hallucinations under these circumstances must be dependent on a focal lesion, I at once excluded the diagnosis of general paralysis and fixed on one of Lues cerebro-spinalis. The importance of a proper diagnosis in such cases is obvious, because the prognosis depends on the diagnosis.

Indeed, I have had the above mentioned patient under observation during a period of six years, but his condition has not changed for the worse: he plays cards and chess, exhibiting no demential signs; he is neat in dress and shows none of the mental disintegration which should have taken place by this time, had he been afflicted with general paralysis six years ago, when I first saw him in the condition above described.

The matter of using as a criterion the intact habit of neatness and carefulness in dress, etc., is a very important one; this habit is one acquired after long years of training and is also one easiest lost when mental impairment sets in. As regards the loss of memory, it is well to bear in mind that a general paralytic never loses one faculty to a more marked degree than he does another. If a paralytic could use fluently two languages, for instance, French and German, before the disease had set in, he cannot forget one language more than he does the other after the onset of the disease. In other cerebral affections, on the contrary, we often observe that there is a loss of one faculty to the exclusion of another.

Important points of differentiation in dubious cases are those relating to the state of the will power. The general paralytic exhibits no constancy of purpose, no sequence of acts and no perseverance. His actions are intimately connected with his sensory state; a slight change of mood is immediately followed by change of act. We seldom see a paralytic occupy his mind with abstract thought; he is easily influenced by his surroundings and is the least troublesome patient in the establishment.

As regards individual nervous disturbances in general paralysis, it must be remarked that they are not characteristic of this disease. Local paralyses, pareses, paræsthesia, anæsthesia, ataxia (Westphal's paralysis) and similar disturbances, are not attributes of general paralysis. Wherever such disturbances, indicative of focal affections, appear, we are justified in excluding the diagnosis of metasyphilis and consequently of general paralysis; on the contrary, syphilitic focal affections should be considered under such circumstances.

When some functions on one side of the body appear intact to the exclusion of those on the other side, general paralysis should also be excluded, for the reasons given above. Normal knee reflexes on one side of the body, for instance, and abnormal ones on the other should at once put us on guard against diagnosing the presence of general paralysis; as has been explained, such conditions imply that a focal lesion is at the root of the disturbance.

The examination of all the functions and of all the organs is of importance in the study of general paralysis. The uniform affec-

tion of all the organs may be said to constitute the particular complexion of general paralysis. The internal organs seem to undergo a parallel wasting and one easily finds a diminished percussion area of the liver, spleen, etc. Cardiac examination generally shows weakened sounds and the blood loses its bacteriocidal properties.

In the digestive function, a gross impairment points towards local syphilitic involvement; thus, in tertiary syphilis this can easily be the case. A point to guard against in the making of a diagnosis as indicated here,—the exclusion of focal disturbances as signs of general paralysis, is the following: a general paralytic may have been subject to gastric catarrh before the parasyphilitic process had set in; the presence of apparently local disturbances does not here exclude the diagnosis of general paralysis. The cases of general paralysis said to have suffered from focal and local disturbances are simply doubtful cases of this kind; it is reasonable to suppose that they were rather cases of focal syphilis.

A difficult question is that concerning the transformation of lues cerebro-spinalis into general paralysis. Theoretically, such a change may take place: focal syphilis may become transformed into diffuse syphilitic infection. Such cases are seldom observed, however. Syphilitics with local morbid manifestations generally yield readily to specific treatment, and there can be no particular reason for such a transformation. If a patient curtails the course of the treatment, however, a difficult clinical development may take place in consequence. A patient undergoes treatment during the course of some time, for instance, improves considerably under such care and finally considers himself cured and stops taking the treatment. He may, then, return within the course of a year, presenting a clinical picture of general paralysis. Such cases are rare, but they exist clinically. They should not confound our ideas on what constitutes true general paralysis. A careful examination of these cases always shows whether or not focal lesions dominate the clinical picture.

So far as I know, there is nothing published on the subject of general paralysis, which brings out the important points which I have tried to elucidate here: the necessity to absolutely separate the disease, general paralysis, properly speaking, from many other forms of diseases, which may be similar in appearance, caused by syphilitic poison, and yet not be general paralysis.

It seems that a great deal of importance is attached to the proper definition of general paralysis, to the understanding of its pathogenesis, its anatomo-pathology and its differential diagnosis.

The treatment of this disease naturally depends a good deal on the correct understanding of what constitutes general paralysis. As

our understanding of the disease is limited, the treatment of it is also limited.

Definition of general paralysis: General paralysis is a parasyphilitic affection of the entire system; the disease depends on a special state of the syphilitic poison (parasyphilitic); the latter decomposes and diffuses its virulence into every tissue of the body. Anatomo-pathologically as well as clinically, general paralysis is characterized by a proportionate diffusion of the poison in and a destruction thereby of the whole organism; not one organ or tissue is more affected than is the other during the progress of this disease. The functions of the organs are similarly attacked in equal proportion.

In progressive paralysis the lesions are of a generalized nature, while in other syphilitic affections (*dementia ex luesiane cerebri organica, lues cerebro-spinalis*) they are of focal nature.

When some functions seem to be of normal condition we are justified in excluding the presence of general paralysis. The apoplectiform and epileptiform attacks in general paralysis are dependent on temporary exudates.

The proper treatment of this dread disease can never be judiciously applied until the nature of the disease is intelligently understood.

(*Dorpat, Yourieff, Livonia, Russia.*

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THE STUDY OF PSYCHIATRY OF TO-DAY;— OF WHAT SHOULD IT CONSIST? *

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The subject I have chosen for this paper is so broad in scope and complex in constituency that I shall have to content myself with a mere presentation of it in terms the most general. The first phase of this subject that naturally presents itself to us is the important rôle the proper classification of mental diseases plays in the proper study of these diseases, and the difficulties which erroneous or meaningless classifications throw into our path.

Consider, for instance, the classification of mental diseases in use in one of the most prominent eastern States. I spent three years in one of these hospitals, where I was a Senior Assistant. Realizing, at the end of that time, my ignorance of the science of psychiatry, I left the institution and went abroad to study. What was the psychiatry in which we were supposed to be instructed there? All insanities were divided into the acute, chronic and recurrent manias and melancholias, primary and secondary dementias, imbecility and idiocy, general paralysis, epilepsy and paranoia. We were required to make yearly reports of our cases with the single view of fitting them into the narrow and meaningless limits of these descriptions.

Returning home after a few years' study abroad, I felt it incumbent on myself to learn what changes had taken place in the classifications, and I wrote to the present hospital authorities, asking them to favor me with a table showing the classification of mental diseases as now used under their approval.

The answer referred me to the classification contained in their report, which classification reads as follows:

*Read at the 58th annual meeting of the American Medico-Psychological Association, Montreal, Canada, June 17th, 18th, 19th and 20th, 1902.

Mania, acute delirious.
Mania, acute.
Mania, recurrent.
Mania, chronic.
Melancholia, acute.
Melancholia, simple.
Melancholia, chronic.
Alternating (circular) insanity.
Paranoia.
General Paralysis.
Dementia primary.
Dementia, terminal.
Epilepsy with insanity.
Imbecility with maniacal attacks.
Idiocy.
Not insane (includes cases of alcoholism, drug habits, etc.)
Unclassified.

I must acknowledge that I had to look at this classification a second time to make sure that I was really awake; some thoughts of Rip Van Winkle's long sleep flitted across my mind; I will not say whether the thought did or did not apply to those in authority. What was particularly interesting was the fact that this classification had been in use continuously since 1888,—a period of fourteen years,—and without change!

Need I recall here the numerous changes of classifications of mental diseases that have taken place during this time? Every day, almost, witnesses changes. The earnest studies pursued by psychiatrists have modified and re-modified the classifications and made them more rational from day to day; in some instances, as you know, these accurate and pains-taking studies of the histories of some mental diseases have contributed so much to our intimate knowledge of these diseases, that some of the most recent diagnoses give us the nature of the affliction and its prognosis at one and the same time*. In this I refer, particularly, to chronic, delusional insanity of systematic evolution and other clinical varieties of mental diseases. With the history of the first disease mentioned you are all familiar:—it was christened during the period of "monomania" fame,—by Esquirol; Lasègue further studied the nature of this disease and individualized it by its characteristic trait of a prodromal state; Morel, in 1860, pushed the study of this entity still further, and the period of ambition in

*Magnan. *Leçons cliniques sur les maladies mentales*, 1896.

the course of this disease was added to that of persecution. In Germany a parallel evolution took place, which led to results practically similar. Italy and England also contributed their shares of thought and work, and finally, the Physician of Ste-Anne has the honor of definitely and conclusively establishing the four invariable stages of this chronic, progressive, delusional disease of fatal termination.

We cannot long consider the questions involved in the subject-matter of this paper without being brought face to face with the overwhelming importance of the clinical history of the patients. The importance of careful records of cases can never be fully appreciated until one has examined, chronologically, the notes personally made by the psychiatrists whose works have marked epochs in the history of research in the field of mental diseases. There, indeed, one finds, not general and flimsy statements to the effect that a given subject is suffering from mania or melancholia, acute, chronic or recurrent; these records, on the contrary, are replete with details relating to the character of the given mania or melancholia; the greatest attention is given to the question of the systematization or lack of systematization of the individual psychiatric phenomena, to the peculiar deviations of some forms of melancholic depression or maniacal excitation, and endless records exist of accompanying disturbances of the general or special sensibilities. So full of detailed study are these records that when we read them to-day, we are immediately enabled, in many instances, to classify the cases in accordance with the latest requirements of detailed scientific nomenclature. What is the system in other countries that produces this condition? For an answer, let us compare the working-day of a psychiatrist abroad, as I have seen him work, and that of our own asylum physician:—

The first begins his day's work by examining the cases received during the previous day; he personally makes notes on these cases, he personally examines some cases which are kept for observation, and personally makes records of them at every examination. This work begins in the morning and continues daily until noon, or later. The afternoon and evening of these men is also devoted to concrete work: every one of the leading psychiatrists, with very few exceptions, is an editor of some leading psychiatric publication; his hours outside of the sick wards are, consequently, taken up with study and reading on the science of psychiatry; besides this, many of these men find time to devote to appropriate laboratory work.

Considering the difficulty and complexity of the study of the science that interests us, we are not at all astonished to witness

such activity on the part of the European physicians in the field of psychiatric research.

Do we find the same manifestation of activity in the study of insanity among those who have in their keeping the welfare of our own insane?

I shall answer this question by citing the routine of a day's work of a superintendent in a certain large institution for the insane in the United States.

At nine o'clock in the morning, the superintendent's work commences. It does not commence where it should,—in the sick ward, where case on case finds its way into the wards of the hospital, presumably to be examined, diagnosed and treated according to the latest indications of science. The superintendent's work begins at the administration desk: here he finds numerous letters relating to the administrative part of the hospital; he spends his morning in dictating to his stenographers, in reading administrative documents, in telephoning to the various commercial agents about supplies of foods, dresses, dry-goods, etc.

At noon, or thereabouts, the superintendent's work is completed; if it is resumed in the afternoon, the character of the work is quite similar to that carried on in the forenoon.

I have left to the last one of the more important duties that the superintendent discharges: that of dictating the diagnoses of the newly admitted cases.

Those of you who have a true and scientific insight into the study of psychiatry and into the difficulty attending the making of a proper scientific diagnosis of a case afflicted with mental disease, realize, no doubt, the parody involved in the assigning to a superintendent above described of a duty that should never be imposed on any person other than a thorough psychiatrist, whose daily life is devoted to such study of the science as can fit him for that sacred task,—the making of proper and scientific diagnoses of mental diseases.

You are all familiar with the features of the “making of diagnoses” in our hospitals for the insane: the first Senior Physician, who has learned from the ward attendants the art of “making diagnoses” is the first “maker” of the diagnoses. These are “put down” in the records in pencil, subject to modification by the higher authority,—the superintendent, whose daily occupation forces him to devote his time to telephoning about underwear, condensed milk and other like matters, which do not seem, from a scientific standpoint, to have any intimate relation to the study of psychiatry, or preparation for the making of diagnoses of the thousands of cases that pass through his wards. I have advisedly

used the expression the “art of making diagnoses,” for this performance is no longer a scientific conclusion based on clinical observation, but, on the contrary, a true artificial grouping of cases.

Thus, under the abnormal scientific condition existing in some of our hospitals for the insane to-day, the diagnosis of every case is reduced to very narrow limits. Indeed, the existing method employed may accurately be compared to that used by a character in Molière to explain the reason of the soporific action of morphine: “It is soporific because it puts to sleep.” Our cases are, similarly, those of acute mania, because they seem to be maniacal; they are cases of melancholia when they look depressed; they are unclassified when they seem to be neither maniacal nor depressed, but manifest insane acts; they are dementes when they seem to be demented, etc., etc., etc. In a word, our hospital attendants could very well pass creditable examinations in the science of psychiatry, if in these examinations the above mentioned classifications were given as tests to determine their proficiency in grouping mental diseases.

You will not be astonished, therefore, to find recorded a case as having suffered from “hypochondriacal melancholia with delusions of persecution,” because the patient “complained of pain in the abdomen, looked depressed, and complained that her husband had wrongfully committed her to an asylum, whereas she should be treated in a general hospital.” You will not be astonished to learn that one of the physicians, who examined her and who was less hardened than was the balance of the staff to the stereotyped diagnoses as above stated, concluded that the patient was not insane, that her jaundiced appearance and abdominal signs pointed to some grave organic trouble; you will not be astonished to learn that the woman died soon after her admission to the hospital,—not of “hypochondriacal melancholia with delusions of persecution,” but of chronic peritonitis caused by a rupture of the gall bladder and the escape of large and numerous gall-stones. (I have some of these stones in my possession.)

You will, similarly, not be astonished to learn that another case was diagnosed as being one of “melancholia or dementia,” because she “did not understand questions addressed to her and looked melancholic.” You will not be astonished to learn that, on the strength of this diagnosis, the patient was compelled to walk in file with the other patients, in the morning and in the afternoon; and you will not be astonished to learn that one of the physicians, less harden to the stereotyped schedule of diagnoses, found that the patient was suffering from a fractured skull, and that the reason she “did not understand questions addressed to her” was that

she was in a condition of most typical mental confusion, due to a fracture of the skull and injuries of the brain. You will not be astonished to learn that the autopsy verified the diagnosis made by this doctor, who was not quite hardened to the stereotypias of diagnoses above referred to.

As I must curtail my paper as much as possible, I shall not multiply the rougher examples of the disadvantage of clinging to an old and discredited classification which we have made far more hideous than it ever was in the hands of its originators. I ask your permission, however, to make some short remarks bearing on the finer traits of classifications. To my mind, the noblest part of the classification considered here is that designated by the term "unclassified."

Any case brought under this heading redeems, from a scientific standpoint, a number of commissions as well as of omissions under the numerous specific headings.

Indeed, you have seen how disastrously one may be misled, when following, in general terms, the classification above referred to. The predicament becomes far more complicated, however, when the nursling of that classification presumes to be a mature psychiatrist and, not content with simple statements to the effect that a given case is suffering from mania, melancholia or dementia as above defined, makes some flighty attempts with a view to the qualifying of the same diseases.

Thus, for instance, when we are told that a case is afflicted not only with "melancholia," but also with "homicidal or suicidal tendencies," the new diagnosis puts us in a far more difficult position than we were before the qualifying term was applied, if we wish to know the variety of psychosis from which the given patient is suffering.

Thus, as in the classification which we are considering, all cases of mental depression, with or without homicidal or suicidal tendencies, must come under the same heading,—that of melancholia; we are at a loss to know with what kind of a psychiatric variety we are dealing; is it a case of that dread disease, which, once properly classified, gives us a complete picture of the subject,—of the graded, systematized, chronic and fatal disease, with which no other form of melancholia should be confounded if a proper history is appended; a history showing the disease to have been slow in onset, but attended by marked periods of evolution (incubation, persecution, grandeur and dementia), in a word,—is it a case of chronic delusional insanity of systematic evolution? or is it a case of a psychosis with delusional interpretation as a basis? or is it a case of general paralysis with demential manifestations?

or is it a case of simple mental debility with homicidal tendencies, as was one of my cases? or is it a case of simple mental degeneracy with commanding hallucinations to kill himself, as was one of my cases? (1) or is it a case of mental degeneracy with delusions of grandeur and reactive manifestations, as was one of my cases? or is it a case of perversion of the instincts, as was one of my cases? (2) or is it a case of morbid obsessions or of impulses, as was one of my cases? (3) or is it a case of mental degeneracy with alcoholic excitation, as was one of my cases? or of hysterical delirium, etc., etc., etc.

I have said nothing about the possibilities of combined psychoses in the same subject, who may attempt or execute suicide or homicide, by reason of two distinct psychoses to which he may be subject, as were some of my cases (4), the manifestation of the respective psychoses bearing the distinct characteristic of the mental affection that prompts the morbid deed. I also refrain from wasting your time on the consideration, from a psychiatric standpoint, of other unintelligible headings in that classification, as, for instance, "terminal dementia" and "imbecility with maniacal attacks."

You have all handled a sufficiently large number of cases to be able to appreciate the fact that a simple numerical statement regarding cases of terminal dementia is as valueless as would be a simple statement that a certain number of cases in a general hospital had suffered from fever. As regards the term "imbecility with maniacal attacks," this definition is unintelligible to me. If the author of the Report above referred to is willing to dignify the entity "imbecility" with a distinctive qualification "maniacal attacks," why should he not, with similar generosity of terminology, call for imbecility with "melancholic attacks?" And why should there be shown such marked miserliness in the matter of appending qualifying terms in the case of idiocy, which figures unqualified? So far as my knowledge of the mentally defective extends, maniacal excitation and melancholic depression is possible of manifestation wherever brain tissue is not totally extinct. Indeed, I have seen some striking cases of microcephalic idiocy with excitation, or with depression, and I have no doubt that many of you have observed similar cases. Besides, I confess that I cannot grasp the importance of this fastidious classification in the case of imbecility, when mental varieties of the most vital importance are allowed to dangle indiscriminately between the limitations of maniacal excitement and melancholic depression, the labelling of a case by the first or the second of these terms depending entirely on the accidental mood in which the given case is found to be at the time of admis-

sion to the hospital, as I have explained. So far as the leading schools of psychiatry classify diseases of the mind, imbecility is considered by the majority a clinical entity; but I have yet to be convinced that "imbecility with maniacal attacks" constitutes a clinical entity, as the report referred to would have us believe.

I do not think that it is necessary for me to continue my course of reasoning much longer to demonstrate to you that at present the vast clinical material found in our hospitals for the insane is absolutely lost to us, if we wish to utilize scientifically the records of the patients in the institutions for the insane.

None of you here will deny the great importance of having intelligent records of patients. We all know how important it is not to confound a case of reactive homicide, for instance, of the *persécuté-persecuteur* type with that of chronic delusional insanity of systematic evolution, or with that of morbid impulses, combined with a systematized delirium, or with that of psychoses with delusional interpretation as a basis. When we designate a disease by a given term, that term should convey to us the idea of whether or not the disease is curable.* When we say that a patient is suffering from morbid impulses, we say at the same time that a cure is probable as well as possible (5); but when we say that a patient is afflicted with chronic delusional insanity of systematic evolution, we say at the same time that the prognosis is most grave; again, when we say of a case that it is one of simple systematized delirium, no matter how grave that delirium, no matter how marked the syndromes of suicide or homicide are in their manifestation, we are almost always right in looking for a favorable termination of the first attack of the disease, at least.

It is true that the Report above mentioned has one heading which I have not mentioned,—paranoia; but how can we expect the disciples of that classification to make a correct diagnosis of the disease, when they do not seem to consider in their classification a whole group of diseases with which paranoia may easily be confounded,—when every other disease that they think is not paranoia must necessarily be mania, or melancholia (acute, chronic, or recurrent)?

It is not necessary for me to explain to you that the number of clinical entities of mania and of melancholia is quite limited and that it has long ago been established by psychiatrists that the terms "maniacal excitation" and "melancholic depression" are expressive only of a group of syndromes common to almost every psychosis in the scale of mental diseases. Indeed, the younger

*Magnan. *Leçons cliniques sur les maladies mentales*, 1896.

psychiatrists have even gone so far as to completely strip these varieties of the common syndromes (maniacal or depressive) of their clinical significance. Magnan totally disregards these syndromes as bases of classification; he justly points out that we all know that one and the same case may be now maniacal and now melancholic in form, and yet suffer neither from mania nor from melancholia. You may judge, therefore, that when we are told in the Report above referred to that during a course of fourteen years there have been admitted 15,082 cases of the manias and 20,-331 melancholias, as above defined, we have not the slightest conception of the kind of mental diseases that have been confounded under these headings; 13,170 cases figure under the heading of terminal dementia, and also leave us in ignorance of the form of insanity which thus ended in mental disintegration. These figures are given from the total number of admissions,—59,693.

You do not have to stretch your imaginations very far to recognize the great truth that maniacal excitement and melancholic depression are as similar to each other as heat is similar to cold. I should venture to state that there is even a far deeper relationship, a far more intimate connection, between mental exhilaration and mental depression. You can easily multiply examples from your own experiences in support of my statement.

Even the uninitiated in the science of psychiatry can readily see that mental exhilaration is a condition not so very remote in nature from that of mental depression; he can recognize the fact that the more a state of exhilaration is marked in degree, the less does that exhilaration resemble the condition which we are wont to term "exhilaration." I need not tell you that when we closely examine the physiognomy of a subject at the very height of "exhilaration," the expression of his features belies the nature of the mood which he is enacting: the psychiatrist, who can see clinical manifestations, cannot fail to notice that the psychiatric background of most effervescent "exhilaration" is profound depression. Every one of you has observed, no doubt, the truly deep depressed psyche of subjects in a condition of most marked "exhilaration."

If the conditions of exhilaration and depression are so similar, we are not justified in making a separate clinical entity of each of these similar conditions; we should seek, on the contrary, a more reasonable basis for the grouping of our cases than is that furnished us by a shifty transition of one mood into another. Take, for instance, the following example:

A woman was so completely depressed by the fear that her brother would be killed in the late Cuban war (where he was about to join his regiment) that her friends became deeply

concerned regarding her condition. An entertainment was arranged, therefore, with the express purpose of diverting her melancholic thoughts and of keeping up her courage, as news from the battlefield was expected at any moment. Touched by the delicacy and thoughtfulness with which the invitation to attend the entertainment had been extended, the woman accepted the invitation. On entering the room where the entertainment was given and on facing the hostess, who was a devoted and sympathetic friend, the woman broke down and begged to be excused and allowed to go home. This the hostess refused to do, insisting that she remain. The woman allowed herself to be governed by her friend, and as some dance music was being played, the hostess insisted on her friend dancing some "figures" by herself. There was a refusal at first, but as the coaxing persisted the woman suddenly arose from her seat and began to dance (some fancy dances of which she was fond), by herself, whirling around the room until she was tired. She sat down to rest, but far from being depressed, as she had been when she came into the room,—she now carried on a lively conversation, which, to those who knew her, was decidedly exhilarated in character and quite unlike the manner of her usual conversation. The music struck up again, and again she got up and danced. This was repeated several times during the evening. When taking leave of her hostess, however, the expression of her face belied the apparent exhilaration of spirits: the melancholic depression was present to the fullest degree, and on reaching her home she indulged in a long crying spell.

When explaining to her friend the sensations during that evening, the woman stated that the sudden onset of exhilaration was a voluntary act at first, because she felt in duty bound to respond to the great kindness and concern of those about her; that while she was whirling to the strains of music the voluntary act had almost become an impulsive discharge which she had no inclination to cut short, because she felt that she could no longer endure the strain of the worry, and that these moments of forgetfulness were most welcome.*

Simple as this example appears, it is yet of great importance from the standpoint of the study of the transformation of human sensations. After all, what we know of disease is only of comparative value with the knowledge of health. This simple example of healthy transition of moods is daily multiplied before us, in pathological forms, in disease. Indeed, you all know that in a

*Since her childhood, this woman has been accustomed to seek "forgetfulness" in the excitement of dancing, of which she was fond.

large number of cases of so-called acute mania the disease begins with a prodromal stage of mental depression; you all know that this merging of melancholic depression into maniacal ex-citement, and *vice versa*, is a common clinical feature; you are all familiar with the profound crying spells of patients afflicted with acute mania, in the midst of the wildest manifestations of delirious grandeur. You are familiar with the marked absence of delusions and of hallucinations in the recognized clinical entity,—acute mania; every clinician must admit that, to all appearances, acute mania is an exaggerated form of normal mentalization: as in the example above cited, where we witness the initial depressive condition, the stage of exhilaration is hardly ever observed in its purest form,—without some depressive phases; the wildest forms of incoherency of speech and of action, when closely examined, show that delusions and hallucinations hardly ever (if at all) enter as elements into the apparently disconnected language and reactions. The incoherent addresses to apparently imaginary persons are, in reality, simple expulsions of verbal images, which correspond to an overcrowding of mental representations; these latter come and go, in rapid succession, so rapid, indeed, that incoherency is the result. Similar incoherency may often be observed in connection with a normal person, who, under mental stress, bent on suiting his innumerable mental images to the shortest limits of time, blurts out, so to speak, certain words or phrases; these are spoken in a louder tone of voice than usual, as if the subject wished to better fix his own attention, which is distracted by numerous other mental representations; these sentences, thus uttered, cannot be understood by any person, except the one whose intimate knowledge of the rapid speaker's personality comes to aid in the linking together of the words and phrases, which would remain insane utterings to the uninitiated.

The closing scene of the morbid entity under consideration is not less comparable to its prototype in the normal state than are the stages already examined: the convalescent acute maniac—a recent brilliant utterer of scintillating remarks, a person with highly perceptive faculties and of sharpened sensibilities,—is now no longer comparable to a turbulent sea under a mantle of effervescent foam; he is rather like the muddy water of an erstwhile stirred up sea: his pre-eminent feature is mental depression (as was the case in the normal person above referred to), the mental brilliancy is replaced by dullness, the perceptions are rather stunted,—in a word,—mental sedateness has crowded out the stage of exhilaration.

If, therefore, we have one morbid psychic entity which lends it-

self to the psychic analysis from the standpoint of its relation to ordinary psychological phenomena, we should guard this clinical entity as one would the key to the deepest mystery of treasure; we should refrain most scrupulously from confounding this entity with some episodic manifestations of other psychoses, which cannot and should not be compared to the entity known as acute mania. Regardless of this simple truth, however, we find no heading in the Report above quoted for this clinical variety; on the contrary, it seems to figure alongside with maniacal excitations with delusional and hallucinational accompaniments of the degenerate. And yet, what a vast clinical difference exists between these two varieties! My friend, Dr. Ferrari, of Reggio-Emilia, has explained in very simple terms the nature of psychoses with delusions as stated, and the mental limitations observed there (6). Not only is the clinical picture different in both cases, but the prognosis, as well as the question of recurrence, is totally different in these two cases: in one, the disease may never occur again,—while maniacal excitation with or without a systematized delirium of the degenerate may recur an indefinite number of times.*

You all know that achievement in all branches of science has been attained by the study of the simplest manifestations. When we find that some simple clinical manifestation lends itself to analysis and understanding by us, we must hold on to it and jealously guard against its becoming confounded with some unknown complexity. The simple description of the transformation of mental states above cited, although not definitely concrete regarding the process of the transformation, can still serve us as a clue to the study of the structure of hallucinations, illusions and delusions. In the entity known as acute mania, we are confronted with one of the most instructive mental phases; if properly studied, we may, perhaps, find ourselves gradually led on to the understanding of the construction of illusions, delusions and hallucinations. It seems rational to suppose that careful observation of the illusions, delusions and hallucinations, which do not regularly take place during the course of this disease, would shed much light on the genesis of these morbid elements: their uncharacteristic nature here, their rapid birth as well as their easy disappearance—are all so many sources of facility in the study of their structure.

Drs. N. Vaschide and Cl. Vurpas have presented a most creditable study of the structure of these psychiatric elements (7). Simple as these elements appear to be at first sight, the knowledge of their structure would be one of the most important achievements in the domain of psychiatry.

*Magnan. *Leçons cliniques sur les maladies mentales*, 1896.

We understand, then, the importance of having a proper classification of mental diseases in our hospitals; this change should be sufficiently intelligible to help us to completely separate certain morbid entities from a complexus of symptoms that may appear under similar forms and sometimes resemble clinical entities with which they have not much in common.

Are not the clinical points brought out here of sufficiently material weight to cause us to abandon the unscientific and unfounded classifications which are in use in some of our hospitals for the insane? Is it not time that we dealt intelligently with our clinical material, so that the clinician might be enabled to furnish intelligible data to the pathologist in his bio-chemical and other investigations?

Is it not time for us to learn that a symptom of a disease must not be taken for a clinical entity?

Looking back to the days of "monomania" fame, when accidental symptoms of diseases were taken for clinical entities, we find that there was much cause for reproach to the originators of this classification (now obsolete in the land of its birth). On close examination, however, we find that these originators, even when the promiscuous mania and melancholia nomenclature was at its zenith, were never quite as unreasoning followers of the classification as those who have imported and adopted it have proven themselves to be. Indeed, as far back as the end of the eighteenth century (Paulus Zacchius, Boerhaave, Larry, Rush and Kant) and the beginning of the nineteenth century (Morel, 1809), the workers in psychiatry had begun to break away from the slavish nomenclature based on detached symptoms of mental diseases (8).

Does it not seem appalling that we should here, in this country, still cling to a discredited and unscientific nomenclature of mental diseases, which we borrowed in an emergency so many years ago?

Under the great pressure of progress we find that even the most strenuous reactionary administrative bodies have found it necessary to yield to the coaxing of science for permission to penetrate into the hitherto tightly locked doors of the hospitals for the insane. Thus, we witness, with a sense of much gratification, that bio-chemical investigation is making its first appearance in some of these hospitals.

A Psychopathic Institute was even founded in one of our leading States under the administration that preceded the present one; and we all feel deeply grateful for the re-opening of that Institute. In order to properly derive scientific benefit from the facilities afforded by this Institute, however, it is absolutely necessary to

change the classification of mental diseases at the earliest moment: the biologist must be guided by the indications of the clinician; he must be given concrete histories of patients by the latter, if he is expected to draw any intelligent conclusions from his laboratory investigations. The microscopist, the morphologist, the cellulo-pathologist, the anthropologist and the other workers in the sciences that should be treated of in the psychopathic laboratory,—all depend, in their work, on the data furnished by the clinician.

This fact is so axiomatic that I need not stop to demonstrate it.

We are in urgent need, then, of accomplished psychiatric clinicians. Where shall we find them? From what precedes in this paper, it would appear that the authorities entrusted with the sacred duty of administering to the insane ought to extend every inducement to clinicians in mental diseases to come and spend some of their time in the furthering of the study of the patients in the hospitals. In fact, the idea even suggests itself that it were not amiss, in our case, to emulate the example of our distinguished compatriot, Mr. Carnegie, who “imported” engineers for his mills, when he found that he could not get sufficient aid from the native artisans; it seems that it were less shameful for us to allow the medical staffs of the hospitals for the insane to learn the fundamental principles of psychiatry from foreign students, if necessary, than it is to allow our staffs to go on in the old rut of comparative freedom from the knowledge of insanity.

I have led up my argument to a most important point in the latest history of the evolution of psychiatry, under the present government of our hospitals for the insane.

What shall we do with our medical staffs and systems in our hospitals?

The most rational method, in all matters of antiquated systems, generally seems to be a complete abolition of all that is old and decayed: one should not build a modern “skyscraper” on the foundation of a superannuated shack.

It is the fate of progress in some branches of science, however, to progress conventionally. I do not attempt to explain the reason for this, because none exists. Psychiatry, with its practical applications and administrative appendices, is one of the sciences which have, thus far, progressed most conventionally. We must therefore, continue in the routine advance.

I would suggest that the present superintendent remain what he has always been: the superintendent of the asylum; I should further consider as a very desirable feature the following: that the proper authorities seek the best workers in mental diseases in this country and extend them attractive inducements to engage in ac-

tive psychiatric work. This method is not very new, as one similar to it has been in vogue with many a college in this country. In this manner the staffs may gradually be revivified and new strength infused into them. When this is accomplished we shall not have to listen to an argument from a superintendent of one of our leading hospitals, couched in the following language:

"I do not see my way to meeting your wishes in the matter of having free access to patients and clinical histories in this hospital. Similar application is made from time to time by so many applicants, that the granting of all—as must necessarily follow the granting of one of the requests—would, in my judgment, seriously interfere with the regular administration of the hospital.

You will understand that this is a general opinion, which has been held and applied for years, and has no personal bearing whatever." *

When "opinions" like the above cease to have practical influence in our hospitals for the insane, and when every applicant desiring to study psychiatry can do so without finding barnacled obstacles in his progressive march; we shall be on a fair road towards divesting ourselves of that thick mantle of ignorance in the science of psychiatry which we have worthily worn for so many years.

By working faithfully in the line of clinical research, we may succeed in grasping many tangible points in psychiatry which can be verified and demonstrated experimentally in the laboratory.

The laboratory enthusiast, on the other hand, who fails to see the paramount importance of clinical work in psychiatry, can do us no harm: he will soon convince himself of the simple truth enunciated by one whose name escapes me: "the mystery of psychic phenomena cannot be resolved by examinations of nerve sections under the microscope," he said, "because a nerve, in its relation to the fundamental sources of psychic manifestations, is quite comparable to a telephone wire in its relation to the central battery: we can get no information regarding the electric force which courses through it by studying a section of the wire that transmits the current." MM. Vaschide and Vurpas, quoted above, have demonstrated the same truth.

Even experiments on live animals cannot supplant or be substituted for clinical manifestations on man: we can induce Jacksonian epilepsy, for instance, in animals, but, barring the delirium caused by extraneous poisons followed by convulsions (*absinthe*), we cannot bring about a spontaneous post-epileptic delirium in all its varieties (apparently conscious acts accomplished in a state of

*Extract from letter written to applicant for permission to pursue psychiatric work in a public hospital for the insane. The author of the letter from which the extract is quoted, cheerfully consented to its publication.

complete unconsciousness). Neither can we study, experimentally, on animals, any of the simplest morbid manifestations of the function of speech, as agraphia, alexia, paraphasia, pure verbal deafness, amnesic aphasia, amusia, etc., etc., because we are not yet familiar with the various shades of animal language or with those of their accomplishments that correspond to the ones above applying in the human being.

There are many more human phenomena which cannot be studied experimentally on animals. I have reference to some psychiatric phases manifested as human invalidity, so-called. I am indebted for the illustration below given to a business man who is interested in human manifestations. Discouraged by the dishonesty of some of his trusted confidential employees, he ventured on an experiment recommended him by a friend,—that of employing a man who has been known among his low associates for years as a “blear-eyed rat.” The nick-name fully describes for you the social, financial and individual standard of our subject; he was the sort of human outcast, with numerous stigmata of degeneracy, passing his life along the river front, where starvation, excesses and multiform degradations intermingle to help finally disintegrate an undermined and devitalized mind and body.

The result of the employment of the irresponsible social outcast for a period of something like a year is that he has “become a man,” is thoroughly devoted to the interests of his employer and has shown himself to be an efficient judge of business matters.

You will agree with me that for the present we must admit that neither our cellular pathology nor our biological experiments can in any way explain to us this mysterious transformation in human morality. You will all agree with me that even the matter-of-fact anthropological data,—the immutable indeces of the high grade and the low in the animal scale, seem to lose their time-honored prestige when applied to cases like the one I have related here: our “dock rat,” remains the same individual subject, and it is reasonable to suppose that his frame has not undergone any fundamental changes that might account for a corresponding and spontaneous evolution towards an irreproachable moral standard. Before any of you utter an objection to the validity of my illustration because of its being a “single” example, allow me to fortify it by the citation of many thousands of similar examples, showing that psychiatric manifestations should be studied far more carefully and far more closely than they have been studied up to the present time. I refer you to Dr. Alexander Southerland’s report (9), showing that 40,000 descendants of criminals transported to Australia (beginning with the year 1850) are peaceful citizens

and furnish, in some instances, a smaller percentage of criminals than do some European nations, not stigmatized as being descendants of criminals.

We have, up to now, made much progress in the science of psychiatry: we have learned the important rôle of heredity, alcoholism, neuroses, etc., as factors in the causation of insanity; we have utilized the information given by laboratory work and have found that intoxication and auto-infection are, according to some physicians, important factors in the etiology of the diseases of the mind; we have learned that the most efficient curative method of insanity is humane treatment; we have learned that the least efficient treatment of criminality is imprisonment, and finally, we have learned that the re-education of the degraded criminal is a valuable aid in the transformation of his vicious character.

We have not yet learned that which we have not studied: education as a preventive measure of both insanity and criminality.

Our finest curative results of the insane and the improvement of the criminal are obtained through the process of re-education (cleanliness, proper food, accommodation to surroundings and self-restraint). If re-education can bring about such satisfactory results in cases so difficult to treat, how much benefit could we then derive from a more direct and healthier method,—that of applying the proper instruction before the mind becomes shattered, when our subjects are yet children?

During the entire course of our schooling, we are seldom taught to understand the true dignity of human life and its limitless possibilities; we are seldom taught the value of endurance, work, perseverance and courage in the broadest sense, as one should consider it in relation to every day life. Yet what valuable aids are these elementary traits in one's nature? I have no hesitation in stating that more than one of us has had the experience of going through some mind-wrecking worry, which, when considered coolly and philosophically, should never have taken place, if the cause of this worry could have been clearly understood by the one concerned. We, psychiatrists, are well familiar with the heartrending tragedies of human life, which are due, in a vast number of cases, to misunderstanding and consequently misinterpretation; we are familiar with the rough traits of the genesis of illusions, delusional interpretation and delusions consequent on a whole system of misunderstandings. The most striking example in favor of my argument may be seen in the huge prototype of mental disease,—mental life as a whole: how much mental suffering do we not find in normal man who has not been educated to see facts clearly and so to avoid mental wreckage? Indeed, so marked is the

number of mental wrecks at large that Goethe justly remarked that there were "enough fools at large" for study; that he found it unnecessary to study them within asylum walls.

We are enlarging the study of our branch of science from day to day. The laboratory is beginning to play an important rôle in the study of psychiatry, but we should not delay much longer the study of the relation of education, in its broadest sense, to psychiatric manifestations.

Even the most conservative members of our profession must feel forced to admit, from the example so well brought to light by Dr. Southerland, of Australia, that the study of social life must become one of our main branches of correlative sciences.

The study of psychiatry is the noblest of all sciences. It is our duty to uplift its standard to the highest possible grade. To the psychiatrist is due the honor and credit of having emancipated from torture the most helpless of all the helpless,—the insane. To the psychiatrist is due the honor and credit of having thwarted the legal infliction of penalty on the insane who had committed "crimes." There are two more tasks to be performed by the psychiatrist: the finding of a prophylaxis and a cure for insanity and the finding of a remedy for criminality.

Clinical work is the key to our science. When clinical work, combined with laboratory verifications, can be carried on intelligently in our hospitals for the insane, the physician of the hospital for the insane will be justified in considering his the proudest position in medicine. The conclusions I arrive at are as follows:—

The fundamental principle of psychiatry is an intelligent understanding of the clinical entities.

The classification of mental diseases generally in use here has no clinical basis according to modern science.

This classification should be changed to a more intelligible grouping of cases at the earliest possible moment.

The lack of understanding of clinical entities leads to grave mistakes in diagnoses.

The vast clinical material in the hospitals for the insane can serve no useful purpose in the study of psychiatry, unless the classifications are modernized and the medical staffs are better initiated into the science of psychiatry.

The present policy of some of the officers who have the control of our hospitals for the insane seems to consist in absolutely keeping out workers in clinical psychiatry. This policy is pursued because the free admission of these workers to the wards would, in the judgment of some of these medical officers, "interfere with the regular administration of the hospitals."

This system is intolerable, unscientific and against public policy and should be condemned and abolished.

The work of the laboratory is entirely dependent on intelligent clinical work.

In the European Universities the worker in psychiatry is given every facility to utilize clinical material in the wards for the insane. The authorities in the United States should extend similar facilities here.

The medical staffs should be completely reorganized; this can be done by gradually substituting competent clinicians for the present assistants, as well as by instructing the present incumbents and raising their general standard.

Clinical work in insanity can never prosper until it is put on a par with clinical work in other branches of medicine: invitations should be posted in the various medical schools calling on scientists and students to accept the freedom of the hospitals for the insane for the purpose of studying insanity.

We have learned the value of re-education in the treatment of insanity and of criminality. We should not delay the beginning of the study of the relation of education and social relations to these diseases.

The noblest work of man is charity, and the greatest charity is the spread of scientific knowledge. Our achievements in psychiatry have led up to important beneficial results to mankind; still greater results are to be expected from intelligent work in this science, and no interest should be permitted to dominate us other than devotion to the sacred science we profess.

To conclude:—the great Western continent has taken a place far in the van of universal progress; in many branches of science, as well as of medicine, we are the peers of the entire world; it is meet that we take our proper place in the domain of psychiatry, and there is no question that our achieving this position is only a matter of time, and of a short time, at that. American liberality, American broad-mindedness and American perseverance must triumph. It remains for us to but recognize and acknowledge that our progress is not sufficiently fast, and it will follow as surely as day follows night that we shall soon outstrip our colleagues the world over.

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9. Dr. Alexander Southerland. Compte Rendu, Ve Congrès International d'Anthropologie Criminelle, Amsterdam, 1901.
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AUTHOR'S NOTE:—Some interesting incidents followed the reading of this paper. When the "time limit" of twenty minutes had been reached and the paper was half read, a gentleman, unknown to me, jumped to his feet and shouted: "I am in favor of the continuance of the reading of this paper only if personal allusions are left out!" By a curious process of mental operation, there flashed across my mind a vivid image of my youthful reading, when Dotheboys Hall of Nicholas Nickleby made my flesh creep, and the Yorkshire schoolmaster threatening Dickens with a law-suit stimulated my risibilities. There is no question that the reading of this paper was received with marked disfavor by many of the members of the Association. It is encouraging to note, however, that I was later the recipient, in public and private, of many expressions of gratification and approval from the leading psychiatrists present, as well as from the more progressive and scholarly superintendents of hospitals for the insane. From all of which it appears that it is incumbent on those of us who can do so, to continue in the fight for the "open door" in hospitals for the insane and for the conversion of those of the hospitals that are still merely boarding houses into curative institutions. Insanity is increasing daily: it is our duty to study it, and we cannot do this until we are given free access to the wards of the hospitals for the insane, regardless of our possession or non-possession of "influence."

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Edited by LOUISE G. ROBINOVITCH, B. ÈS L., M.D.

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FIAT LUX!

In pursuance of the policy announced by this Journal some months ago, in which the avowed intention was specified of forcing open to students in psychiatry the hitherto sealed doors of our Hospitals for the Insane, we trust to have the pleasure of presenting in some of the numbers of this Volume rather interesting matter descriptive of the methods used by some of these institutions in excluding scientific workers and students. Convinced as we are that this barbaric system of secrecy, seclusion and exclusion must be done away with if our unfortunate insane population is to have any scientific consideration at all, we feel it incumbent on us to keep up this battle for what is both right and just. The immortal Pinel, when he struck off the manacles of the insane, left the shackles there, unfortunately, to be remodelled and, in certain localities on this side of the the Atlantic, to be duly adjusted upon the portals of the institutions themselves. It remains for this generation, therefore, to go a step further and to do away with the moat, drawbridge and portcullis which, figuratively speaking, still approximate a number of our Hospitals for the Insane of this century to the age of chivalry, sorcery, oppression by divine dispensation, secret tribunals and inquisitory determinations of justice.

Since the time when the printing press became a recognized agent of civilization, the influence exercised by the daily press on

the moral and physical, as well as on the political, health of nations has been fully recognized. The various scientific publications hardly ever reach the general public; indeed, great numbers of the professional people find themselves so engrossed in the work attending the daily struggle for existence that they lose sight of those periodicals which strive to keep them in touch with the latest discoveries of their co-workers throughout the world.

Through clinical work the alienists as a body have had clearly demonstrated to them the fact that among the self-inflicted causes of insanity, criminality, and other like afflictions, alcoholism stands as a pre-eminent and predominant factor. The public, however,—the great public whom this fact most concerns, has yet to be instructed in the overwhelming truths which the medical profession itself has so reluctantly accepted. This public cannot be reached by special publications, and there probably exists no medium more adaptable or more potent for the dissemination of this truth than the daily press. It is encouraging, therefore, and gratifying, to find a daily publication strong enough and sufficiently courageous in its disregard of public derision to undertake the dissemination of these principles, and to emphasize them both by narrative and by the use of the artist's pencil. The humane service done in this field of public education by the *New York Journal* must elicit our approval and commendation. This daily publication has been notable for a series of editorials and cartoons, which simple in language and startling in presentation, cannot have failed to have made their impressions on that great mass of people that composes its clientele.

WOMEN NURSES IN WARDS FOR INSANE MEN.

In our issue of June, 1901, we advocated editorially the employment of women nurses in the wards for insane men. We based our argument in favor of this innovation on the results of the employment of women nurses in the wards for acute alcoholic cases at the Philadelphia Hospital (Blockley); we stated that the results of this innovation were most encouraging, and a vigorous suggestion was made that this practice be generally adopted; in this manner alone, we claimed, could we do away with the abuses of patients by brutal attendants.

Some months ago, a note arrived at our office, purporting to come from Sidney D. Wilgus, Ogdensburg, N. Y., presumably a physician, which read:—"One of your editorials on women nurses in men's wards has prejudiced me against your Journal; under no conditions would I take it."

We take great pleasure in referring the author of this communि-

cation to the Proceedings of the meeting of the American Medico-Psychological Association, 1902, published in this issue, during which meeting the suggestion for employing women nurses in wards for insane men was discussed. He will find there that not only was our observation and suggestion in this matter correct, but that the leading American psychiatrists, as well as a number of superintendents of hospitals for the insane, highly approve of our point of view: the employment of women nurses in the wards for insane men is no longer a doubtful innovation;—the special capacity of woman for nursing the sick, whether sane or insane,—whether man, woman or child,—has gained for her a new and vast field of usefulness.

We are in possession of a number of communications from leading psychiatrists all the world over regarding the advisability of the employment of women nurses to care for insane men. The communications will be published in some of our current numbers.

DR. ALEXANDER E. MACDONALD, of the Manhattan State Hospital, East, writes as follows:

Dr. Louise G. Robinovitch.

Dear Doctor: I am in receipt of your communication of the 16th inst., soliciting an opinion regarding the employment of women nurses in the wards for men. In the case of this hospital the practice has been instituted but a comparatively short time, and it has hardly yet passed beyond the experimental stage; so far, though, the service is satisfactory. The patients appear to be amenable to their influence, and also to exercise greater control over their emotions. The lighter hand of the woman is also shown to advantage in the details connected with the patient's bed, his own personal appearance, and not least, in the service of his food and medicine. The service is probably capable of further extension. Respectfully yours,

(Signed) A. E. MACDONALD.

In a private conversation with the reporter of the proceedings of the Montreal meeting, Dr. Edwards, of Kalamazoo, Mich., stated that the moral influence of the woman nurse on the insane man cannot be overestimated; that the patients most rebellious in the hands of the male attendant become submissive and docile when handled by a woman.

CANADIAN HOSPITALITY.—The people of Montreal, Canada, completely charmed the American Medico-psychological Association during its annual meeting in June of this year. The peculiarly agreeable feature of their hospitality consisted in their warm-heartedness and good-fellowship in connection with the gala entertainments given to the Americans. Some of the hosts were: Lieutenant-Governor of Quebec, Sir Louis A. Jette; Dean

of the McGill University, Dr. Roddick; Dr. T. J. W. Burgess, Prof. T. Wesley Mills, the managers of the Protestant Hospital for Insane, of Longue Pointe and Quebec Hospitals; the Hunt Club, Golf Club. Miss Roddick, Mrs. Burgess and daughter, Mr. and Mrs. Lyall, the Mayor of Montreal and M. LeBeuf; many other prominent men and women of Montreal were tireless in their generous hospitality.

We learn with much regret of the death of Dr. Selden H. Talcott, of the Middletown State Homeopathic Hospital, N. Y. Some few weeks ago his friends and admirers celebrated with him the twenty-fifth anniversary of his service in the hospital. He was one of the pioneer physicians not only in America, but in the world, who instituted and successfully practiced the bed-treatment for the insane.

Drs. M. C. Ashley and G. F. Adams are spoken of as candidates for superintendent at the Middletown Hospital for Insane, which position is now vacant.

PROCEEDINGS OF THE FIFTY-EIGHTH ANNUAL MEETING OF THE AMERICAN MEDICO- PSYCHOLOGICAL ASSOCIATION

HELD AT MONTREAL, CANADA, JUNE 17, 18, 19 AND 20TH, 1902.

DR. R. J. PRESTON, in the Presidential Address, made an interesting review of the history of the hospitals for insane in the United States. Valuable statistical data were given and the interesting fact was brought out that the South could boast of being the birth place of many fine humane institutions. The paper was warmly applauded.

DR. E. STANLEY ABBOTT: *The Criteria of Insanity and the Problems of Psychiatry.* A careful study should be made of the various psychiatric acts of the insane, and comparisons should be made between these acts and their corresponding parallels in the normal state. If time does not permit the making of a study of all the cases under the physician's care, he is not hindered from obtaining satisfactory results if he can make a thorough study of one or two cases.

DR. LOUISE G. ROBINOVITCH: *The Study of Psychiatry of Today; of what Should it Consist?* We are in urgent need of a proper classification of mental diseases; the classification applied to cases in some of our most prominent State hospitals is without scientific significance; the vast clinical material handled in the hospitals for the insane is thus lost to us; grave mistakes in diagnoses, detrimental to the patients, are often the results of the application of the present classification. A series of clinical illustrations were cited to show that the present classification is untenable from a clinical standpoint; this invalid feature of the classification forces us to confound diseases of vastly varied natures under one and the same meaningless denomination; we are thus hindered from having a correct insight into the nature of psychiatric disturbances. A thorough reform in

the appointment of the medical staffs is urgent; the physicians entrusted with the care of the insane should give their time to the study of psychiatry; at present, their time is greatly taken up with purely clerical work. (The full text of this paper is published in this issue).

DR. EVANS, of Morris Plains, N. J., discussing this paper, stated that the superintendents of hospitals for the insane who are entrusted with the care of the unfortunates are supposed to be properly qualified to look after these unfortunate people; on the superintendents were imposed not only the duties of looking after the sick, but also of attending to administrative business of the hospitals; it is easy to come before a dignified association and to ridicule methods of superintendents. He made a number of similar remarks but did not touch on any of the scientific points of psychiatry laid before the meeting for consideration in the paper.

Answering, Dr. ROBINOVITCH deprecated the introduction of personal feeling in the discussion of a scientific paper of such importance as was the one under consideration. The Doctor also said: "I fail to see that Dr. Evans has succeeded in his attempt to criticise scientifically the points of psychiatric interest which I have laid before you. A great deal of feeling has been shown, at which I am greatly astonished. The lack of self control is the more remarkable when manifested by medical men; we are going through a critical period in the development of the science of psychiatry and we should be brave enough to calmly accept rebukes if we are found lacking in the knowledge of this science. We should come here for earnest conference and sincere work. Dr. Runge was frank in his statement regarding the problem I have come to consider with you; he said that a superintendent, as he stands to-day, cannot be at the same time a scientific investigator, that the progress of psychiatry must of necessity depend on the scientist; that the superintendents cannot possibly be counted on to bring about progress in psychiatry. If we had more frank superintendents like Dr. Runge, our science would be on a fair road to progress."

DR. ADOLF MEYER: *On a few Important Terminal Diseases of the Insane*,—cases fed artificially for some length of time are apt to manifest pulmonary or enteric complications of fatal termination; this is particularly the case when the process of the feeding is accompanied by resistance on the part of the patient; the inflammation of the organs in the vicinity of the œsophagus or the rectum is probably of traumatic nature. The "insane" ear is also due to violent handling by attendants. The decrease of this malady is in proportion to the gentler natures of the attendants.

During the discussion of this paper it was said that when a patient is obdurate in his refusal to be fed, when the vitality becomes lowered and life is endangered through forced starvation, and the stomach and rectum are in bad condition, saline solutions in large quantities should be injected hypodermically.

REV. JAS. M. BUCKLEY: *The Possible Influence of Rational Conversation on the insane*,—the influence of kindly and judicious conversation on the insane is invaluable; cases were cited to illustrate this truth; a large number of the members approved of this method in suitable cases.

DR. J. ELVIN COURTNEY: *How Near Akin are Insanity, Crime and Degeneracy?* These infirmities have a common basis; heredity is an important factor in the genesis of all these infirmities; criminality is more transmissible than is insanity; criminals are more subject to anomalies of

circulation than are other degenerates; anaemia is a characteristic trait of the criminal; there exists no borderland between insanity and criminality; early commitments of the insane decreases the population in prisons; a number of statistical figures were given; 4 per cent. of all convicts in New York are insane; corrective methods and philanthropy do not lessen the growth of the diseases.

DR. EDWARD B. LANE: *Litigious Insanity*,—a typical case of this variety of insanity was cited; the patient was a wealthy woman; she was the author of many plots against her son, husband, sister, friends and servants; a judge in Boston refused to admit medical evidence of her insanity; she was allowed to be at large and she squandered a vast fortune in the execution of the various plots and litigations in which she was involved; she was finally found dead in a dumb waiter shaft. Dr. Searcy suggested that the term psychosis be applied to similar cases, if there is reason to fear that judicial authorities (as in Boston) hold their opinions above those of expert physicians in matters pertaining to medical knowledge; many a judge would accept the term psychosis and consent to limit patients' civil rights on the ground of their being afflicted with a psychosis; when it is stated that a patient is suffering from insanity and the judge fails to convince himself that such is the actual case,—he is very apt to dismiss the case and thus force a mentally sick person on the community.

DR. COURTNEY: There should be no distinction between medical and legal insanity.

DR. JAMES RUSSELL: *The Psychology of Anarchism*,—anarchism is a social disease; it should be treated before it takes birth—in the school boy; little and imperfect education is an active factor in the birth of anarchism; to be effective, the education of the masses should be liberal and thorough. Repressive laws are useless; in the United States, there are many colonies of foreigners who remain free from education and who easily embrace the teachings of anarchism; to illustrate the lack of popular education Carlyle was quoted as having said: "England contains so many millions of men,—mostly fools."

DR. W. H. KIDDER: *Care of the Insane in Brazil*,—a thorough system of examining the new patients exists in the hospital for insane at Rio-de-Janeiro; anthropometric measurements are taken; the methods used are preferably those in vogue in the Latin countries; chemical restraint is seldom used, if at all; hydrotherapy is greatly in vogue; a patient is never kept in a bath longer than six hours; a training school for nurses is one of the features of the hospital for the insane; patients are kept for observation fifteen days; they are then distributed in wards or in agricultural colonies; there are no grassy lawns; sandy grounds are the prevailing feature, as sand acts as an insecticide; the floors in the rooms are made of tiles; the single rooms are like cells, and the floors there are covered with cement; food is of good quality; vegetables and fruits are abundant; the standard of care is not as high as it is in the United States; that is,—it is not as uniform; but the appropriations are more liberal; the daily allowance per capita is from forty-eight to fifty cents; the general appearance and acts of the insane patient is very much in keeping with the corresponding characteristic traits of the sane Brazilian: he is not boisterous or authoritative; he seems to express the characteristics of one who has been born a subject in a monarchy.

REV. BUCKLEY: In the leading asylum in Egypt there are no cases of alcoholism, but there are hashish cases.

DR. RUNGE: In Syria the treatment of the insane is rather that of veneration; even homicides are allowed to be at large; no one dares interfere with them.

DR. DEWEY: In Havana, the population of the hospital for insane was one thousand; the patients suffered much privation before the war; after the war, General Wood took much interest in the hospital and many improvements were introduced; hydrotherapy is in great vogue there.

DR. MILLER: Civilization is a cause of insanity; the American negro is becoming more and more subject to insanity; there was less of this disease among the negroes when they were slaves.

DR. KIDDER: Hysteria and alcoholism are frequent diagnoses in Brazil; statistics there are unreliable.

DR. EDWARD COWLES: *The Organic Sensations in Mental Pathology*,—mental pathology must be founded on mental physiology.

DR. DEWEY: There does not seem to exist any correspondence between the apparent and the real sensations of the insane.

DR. A. B. RICHARDSON: *Women Nurses in Hospitals for Insane*,—there is a great advantage in having women nurses in the wards for the acute cases of insanity; women make better nurses than do men; in the hospital for insane at Washington, a training school for nurses has been established, and the results are most satisfactory; the entire hospital division is divided into five sections, every one of which is in charge of one head-nurse; after graduation, the male nurses are paid 30 dollars per month and the female nurses 25 dollars per month; later on, they are paid \$35 and \$30 respectively; it is doubtful whether the woman nurse can prove a success in the ward for the chronic insane men.

DR. CHARLES G. HILL, of Maryland: Female nurses care for all our cases,—acute, violent and others; female nurses should be employed in all wards for the insane.

DR. EDWARDS: For a long time, at Kalamazoo, we have had women nurses in the wards for the insane; on ten wards we have women nurses for men; these nurses are all graduates of the training school of our hospital; the ideal nurse is the one who has had previous training in a general hospital.

DR. ALDER BLUMER: In Rhode Island, I have made an experiment in this line; a trained head nurse should be in charge of the women nurses; men supervisors should not have any authority over the women nurses in the wards for men.

DR. E. C. DENT: *Hydriatics as an Adjunct in the Treatment of Insanity*,—hydrotherapy is a valuable therapeutic adjunct in the treatment of insanity.

DR. EDWARDS: Hydrotherapy is of particular value in acute cases; before hydrotherapy was introduced in the Kalamazoo Hospital, which had a population of seven hundred patients, 150 doses of chloral were given daily; since the introduction of hydrotherapy, with a larger population, only ten doses of chloral are given daily; hydrotherapy has replaced chemical restraint.

DR. HILLS, of Baltimore, and DR. RICHARDSON, also spoke in favor of hydrotherapy.

DR. MILLS. of the McGill University, said that every case treated by hydrotherapy could serve as a rich source of study of afferent and efferent impulses.

DR. FOSTER spoke of the combined cold and hot baths and of prolonged steam and hot air baths.

DR. HATTIE: *The Development of Self Control*,—the teacher has in his keeping the moulding of the man; self-control should be developed at school; teachers should be better prepared for their task,—better instructed in physiology and psychology, if we are to obtain better results from their teaching; individual instruction is an important factor in one's education.

An interesting discussion of these views took place.

DRS. MacCALLUM and C. F. HAVILAND presented papers on the treatment of tuberculosis of the insane. Dr. Haviland gave a description of the advantages of using tents for the tuberculosis patients, at the Manhattan State Hospital, on Ward's Island.

DR. WESLEY MILLS, of the McGill University, delivered a lecture on cerebral function; he demonstrated his arguments by animals on whom appropriate operations had been performed with a view to localizing cerebral functions. Screen projections were also used.

A few papers were read by title.

OFFICERS ELECTED for the ensuing year: Dr. G. Alder Blumer, of Rhode Island, President; Dr. A. B. Richardson, of Washington, Vice-President; Dr. C. B. Burr, of Flint, Michigan, Secretary and Treasurer; Councillors, Drs. F. Jelly, of Boston; W. F. Drewry, of Petersburg, Va.; W. H. Hattie, of Halifax; M. J. White, of Wauwatosa, Wis.; Edward B. Lane and James Buchanan.

THE NEXT MEETING is to be held in the State of Rhode Island. The date is to be some time after May, 1903.

DELEGATES appointed to foreign congresses: Drs. Alder Blumer,—to the British Medico-Psychological Association; Adolf Meyer and Alexander E. MacDonald to the International Congress of Medicine, Spain.

CEREBRAL LOCALIZATION AND JACKSONIAN EPILEPSY.—In preceding issues of this Journal were reported some cases, in which tumors of the frontal convolutions were expressed clinically by Jacksonian epilepsy. M. Mirallié reports some additional cases of the same nature (*Progres Medical*, May 10, 1902). M. Lepine's case, a woman, suffered from major convulsive attacks, with small convulsive spells of the fingers and the forearm, with rigidity of the arm, but without loss of consciousness. The autopsy revealed an entire integrity of the Rolandic substance; the lesion was located in the first right frontal convolution and was an old kystic abscess.

Another case of M. LEPINE, a chronic syphilitic, suffered besides other cerebral symptoms, from Jacksonian epilepsy limited to both arms. At the autopsy two symmetrical gommata were found, not in the Rolandic convolutions, but in each of the first frontal convolutions.

MM. FAGUET and LOWITZ had a case of Jacksonian epilepsy, in which the attacks always set in by convulsions in the left hand. At the autopsy, the motor zone was intact; but a syphilitic

gomma was found in the posterior third of the second right frontal convolution.

M. CHIPAULT'S case suffered from Jacksonian epilepsy, which was localized in the left arm and leg; the convulsive symptoms were followed by paralytic manifestations. At the autopsy, a glioma, the size of a cherry, was found, not in the Rolandic convolutions, which were perfectly healthy, but in the right second frontal convolution.

M. DIEULAFOY'S case, which was published in a previous issue of the *Journal of Mental Pathology*, is one in which Jacksonian epilepsy and other cerebral symptoms were caused not by any lesion of the Rolandic region, but by a syphilitic gomma, the size of a small egg, located in the frontal lobe,—its anterior third of the 1st, 2d and 3d convolutions, and the external part of the olfactory convolution; in depth, the growth reached to about $1\frac{1}{2}$ cm. in front of the lateral ventricle.

The other cases are: LEPINAY'S (*Th. Doct., Paris*, 1901, case 5, p. 24). A woman, general paralytic, presented, after an attack of vertigo, a right hemiparesis, most marked on the right arm. At the autopsy, softening of recent date was found in the cortex of the first and second frontal convolutions, extending backward, exactly to the level of the ascending frontal. An old softening existed in the middle of the first frontal; the size of this focus was about that of a silver two-franc coin.

HITZIG (*Therapeutische Wochens.*, 1896. The analysis is given in the *Revue Neurologique*, 1896, p. 521). A man, 34 years of age, suffered from Jacksonian epilepsy and from paresis of the right limbs; it was supposed that a tumor of the motor area existed; the man's skull was trephined, but the results were negative. At the autopsy, a voluminous tumor of the frontal lobe was found. Case 3, related in the same source, is one of Jacksonian epilepsy on the right side, with paresis of the limbs; the skull was trephined and the motor convolutions were exposed, but no lesion was found there.

ALDIBERT (*Revue de Chirurgie*, 1895, p. 158): A woman, 75 years of age, presented convulsive spells during the period between May 25 and August 12; the intensity of the spells increased progressively and right hemiparesis finally set in. The skull was opened, and search made for some lesion of the middle third of the ascending frontal; the autopsy showed the presence of a sarcoma of the foot of the second frontal.

HENSCHEN (*Congres de Moscou*, 1897, Vol. IV, partie I, p. 610): Pettersson suffered, during a period of three weeks, from impaired vision in the left eye and from frontal headaches. Epilep-

tiform attacks took place in the left commissure of the mouth. Epileptic state, paræsthesia of the left arm and leg. Gomma of the tongue. The patient was brought to the Hospital in a moribund condition. The skull was trephined in the middle and inferior part of the Rolandic zone; the frequency of the attacks decreased, but the patient died; the autopsy revealed the presence of a small tumor of the first frontal convolution.

There must exist some other records of similar cases. The question as to whether the theory of brain localization is shattered by these records is to be considered. Jacksonian epilepsy seems to indicate a cortical reaction, the primary origin of which is variable: there may exist a gross lesion in the motor region, a lesion at some distance from that region and, finally, the epilepsy may be due to endogenous or exogenous infection (uraemia, diabetes, alcoholism, etc.). MM. Pitres and Championniere think that when the patient retains his consciousness during the attacks, and when the latter are followed by monoplegia, the diagnosis of a Rolandic lesion is very apt to be correct. (*Progres Medical*, May 10, 1902.)

GENESIS AND NOSOGRAPHIA OF GENERAL PARALYSIS.—PROF. L. BIANCHI: The history of the genesis of general paralysis is having its periods of evolution. The first period was marked by the belief that syphilis was the cause of the disease, and hopes of cure were maintained on that score; the salvation was vested in the properties of mercury. The second period threw a shadow on the previously raised hope of cure; it was no longer the syphilitic poison in the system (parasyphilide of Strumpell) that was considered as being the cause of the disease; the agents born in the organism in consequence of the presence of the syphilitic poison in the system (parasyphilide of Strumpell) were now considered as the cause. The last period is characterized by some scepticism; syphilis as a cause of the disease, as expressed in percentage by various authors, ranges between 90 per cent. and 11 per cent.; it is time, therefore, to embark on different causative roads that will resist better the test of time.

Individual statistics quoted bring to light a vast divergence of figures and show the extent to which syphilis is a cause of general paralysis. Thus, there is 1.6 per cent. (Voisin) to 21.6 per cent. (Obesteiner), 42 (Cullerre), 48.1 + (Urquhart), 51 (Jastrovitch), 64 (Christiani), 75 (Mendel), 77.7 + (Garbini), 88 (Minor), 76.7 (Kowalewsky) and 94 (Regis). Finally, Raymond affirms that 9 out of 10 cases of general paralysis are syphilitic. The author himself has selected 87 cases, the histories of

which were carefully investigated, and shows that in 12 cases only was syphilis the exclusive cause, while it coexisted with others in many instances. Heredity, alcoholism, etc., were causes in the rest of the cases. As regards the abuse of alcohol in relation to this disease, it cannot be considered as being a specific factor in the author's cases, for the reason that in the province of Naples the alcoholic vice is not common; on the other hand, in many other provinces, where alcoholism is quite prevalent, general paralysis is rare in occurrence. Of the 87 cases, 26 were alcoholists. This figure seems to be in proportion with those given by Mendel and Greidenberg, who consider alcoholism as a cause second in importance to syphilis. Greidenberg estimates 14.3 per cent. of the cases as being other causes. Van Derventer considers the abuse of alcohol as being the leading cause; Knudt found 15 cases out of 193 as being due to alcoholism exclusively and in 41 cases alcoholism was associated with other causes. The divergence of opinion regarding the specificity of alcohol is as marked as that regarding the specific agency of syphilis.

HEREDITY is a more potent factor than is generally admitted; in the author's cases it figured 48 times in connection with other causes, and 17 times as an exclusive cause, as against 12 times of syphilis. Greidenberg and Westphal give much lower figures for heredity—4.7 per cent. and 5.4 per cent. respectively. Ameline's figures (Ste-Anne), show that heredity is found in one-half of the cases; this seems probable, as the heredity influence in this disease must be similar to that found in others. Heredity is particularly marked when apoplexy is a leading feature in one or both parents. A case of juvenile hereditary paralysis is cited by the author.

RENAL DISEASE is a frequent cause and is often associated with the apoplectic and epileptiform attacks in general paralysis. Bristowe found 60 cases of renal disease in 75 cases of general paralysis; the author himself has frequently observed the existence of renal disease in cases of general paralysis. Recently, 20 autopsies on general paralytics showed the existence of renal trouble in 13. This would lead one to suppose that either arterio-sclerosis is diffuse in the initial stage and causes this renal trouble, or that the renal arterio-sclerosis induces nephritis and slow auto-intoxication, which leads to apoplectiform manifestations, characteristic of the initial stages of general paralysis in many cases, and ending in slow degeneration of the nervous elements. Some authors also attach much importance to the arthritic diathesis in connection with general paralysis. This disease may also develop after an attack of a simple psychosis, or that of an acute infectious disease, particularly in the young.

SYPHILIS: although a frequent disease in China and in Japan, general paralysis is, nevertheless, a rare disease in these countries; 2 per cent. of the cases of the Tokio asylum for the insane are stated as being general paralytics. The disease is also rare among the Arabs and Mohamedans in general; Serbia, Southern Russia, Scotland, Ireland and Switzerland are also said to be comparatively free from the disease. In the polar countries, syphilis as well as general paralysis are said to be rare in occurrence. A point of interest in this connection is the fact that almost all prostitutes are syphilitic, yet general paralysis is a rare disease among them. Their number is quite large in Naples, yet it is difficult to find general paralytics among them; married women, however, very frequently suffer from the disease, whether they are syphilitic or not. Idanow found only 83 prostitutes among 565 cases of women general paralytics. Wollenberg and Westphal have made similar observations. According to the latter, of 148 women general paralytics only one was a prostitute.

THE CAUSES of the disease may vary, but its form and anato-mo-pathology always remain the same. General paralysis is not a specific disease, but simply a slow death of the nervous elements; this may be induced by numerous causes. Syphilis has no specific action in the causation of the disease, any more than has any other intoxicant agent, such as alcohol, etc.

PSEUDO-PARALYSIS, this term is an ingenious invention for cases, which we cannot diagnose correctly.

REMISSIONS in the disease should be studied carefully; legally the question is often of great importance: some cases may improve considerably during the period of intermission, a most careful examination only revealing the true condition of the patient (*Annali di Nevrologia*, Anno XX, fasc. 1).

REMARKS ON CATATONIA.—DR. PAUL MASOIN. Some authors consider catatonia as being a morbid entity. This question will be considered at length at some future time. Two cases are cited, which presented catatonia during the course of dementia that set in after an attack of acute infectious diseases. The variety of the catatonias differed in both cases: in one, it was of the usual flexible kind, the limbs remaining in any position that was imparted to them, while in the other there existed an exaggerated rigidity of the muscles that was irreducible; there existed no neuro-muscular lesion. Some alienists probably object to the application of the term catatonia to such cases; a further discussion will elucidate this question.

The point brought out consists of the fact that catatonia is not a morbid entity, as the Germans would have it be. Catatonia is found to coexist with various forms of mental disturbance. In the author's case, there was absolutely no correlation between the demential delirium and the *flexibilitas cerea* of the muscular system; on the contrary, there was a complete dissociation between the delirium and the acts. From all points of reasoning, it seems that while the delirium occupies the psychic field, certain motor activities install themselves as manifestations of true *cerebral automatism*.

The author differs in opinion from those of Seglas and Regis, who consider catatonia as a symptom of melancholia with stupor under its various forms. Cases of precocious dementia without accompanying catatonia could be cited.

It is true that catatonia is found to exist preferably during the course of precocious dementia. It is wrong, however, to accept the German view, which holds that there is no hebephrenia without catatonia. The Germans even use the two terms synonymously. The catatonic movements encountered during the course of precocious dementia are not the results of the delirium, but are rather superadded phenomena. The independence of these two elements is such that one may exist to the exclusion of the other. For this reason there does not exist any correlation between these movements and the special sensibility (sight, hearing).

Catatonia is often found in hysterical subjects, epileptic dementes, some general paralytics in the second or third stage, or in senile dementes; they are of very frequent occurrence in idiots. It is astonishing that the great analogy between these movements and the numerous stereotypias observed in the idiots should have escaped notice to a marked degree. Among these subjects can be observed both forms of catatonia,—the rigid as well as the flexible.

Wherever found, these phenomena are of a *demential nature*: there is absence of purpose, of unity, of relation between the movements themselves or with any idea. It is noteworthy also that they are spontaneous in manifestation; in this respect they are identical with the *automatism found in the idiot*. Besides, hebephrenia is only a form of tardy idiocy; this is so true that without having the history of the case, it is impossible to distinguish between an idiot and a hebephreniac at the height of the disease, as the analogies between these two conditions are quite numerous. In both instances, there are cases with or without impairment of the muscular system. The impulses, tics and negations of various forms are in both instances expressions of

cerebral automatism; for the reason of this characteristic trait, catatonia can be found as a complication of various other disturbances.

The author does not consider his reasoning as too enthusiastic in favor of his opinion when he states that there is a similarity between the automatism above considered and that found in epilepsy and drunkenness, where stereotypias are particularly common in occurrence. Moreover, symptoms of catatonia have been observed to take place during stupor following cranial traumatism. Dr. Crocq has compared the condition of catatonia to the cataleptic condition obtained during hypnosis.

All these various conditions have the following traits in common: absence of direction and control of the intelligence; in all cases, like during delirium, it remains inert. All the acts termed *catatonic* are manifestations of *pure automatism*, and as such are found in all transitory or permanent conditions, in which there exists obtundation of the intelligence, impaired consciousness, or in other words, where there exists cerebral stupor. For this reason, the phenomenon is found to occur in direct proportion to the existing cerebral inertia.

This manner of looking at catatonia explains its great variability, according to the subject, as well as its various forms of manifestation in the same subject, according to the cerebral centre involved: motor, (impulses, spells), or the opposite form,—muscular catalepsy, negation, resistance. (*Journal de Neurologie*, Feb. 20, 1902).

EXPERIMENTAL CEREBRAL ATROPHIES. — PROF. G. D'ABUNDO reproduced experimentally cerebral lesions analogous to some that he had observed in three idiotic children. The children seemed to have developed normally until the first year of life, when some febrile manifestations were followed by convulsions and subsequent hemiplegia with loss of speech as well as of intelligence. Case 1, suffered from right hemiplegia with contractures and repeated epileptiform attacks. The autopsy revealed the presence of a classical cerebral hemiatrophy with sub-arachnoid and ventricular hydrocephalus on the left side. The atrophy of the left hemisphere was *in toto*, although the convolutions retained their usual outlines; the corresponding cerebral peduncle, pons and pyramids and the opposite side of the cerebellum were also atrophied. In the right hemisphere, the frontal and first temporal lobes were hypertrophied. Case 2, was similar to the first one; there was right hemiplegia with Jacksonian epilepsy on the right; the autopsy showed the existence of left cerebral atrophy, while the

cerebellum was atrophied on the right side. The cerebral atrophy involved the 3d frontal convolution, the insula and the lower two-thirds of the frontal and the ascending parietal; the lower part of the second frontal and the lower parietal were also atrophied. The hypertrophy of the 1st frontal and 2d temporal on the right side correspond to the atrophy on the left. Case 3, suffered from left hemiplegia with contractures and mental impairment as noted above; the autopsy showed right cerebral atrophy, involving particularly the prefrontal, parietal and occipital convolutions and those in the zone of Rolando and to some extent the temporal lobe. On the left side, the atrophy was limited to the prefrontal, the zone of Rolando and to some extent the temporal lobe; the pons and pyramid tract was also involved.

The author concludes from the histories of these cases that the last developed centres are the easiest to become affected by disease; that infection (alcoholic, syphilitic, etc.) is a marked agent in the production of psycho-neuroses in the child; that the diseased hemisphere acts like a foreign body as a cause of Jacksonian epilepsy which generally accompanies these diseases; finally, that the hypertrophy observed in the uninjured hemisphere seems to compensate in motor activity, but never in that of the intelligence, which is invariably impaired.

Lesions similar to those above mentioned were produced experimentally on cats and dogs, and the conclusions are, in part, that an experimental cortical lesion brings about results similar to those caused by natural pathological lesions; there follows not only atrophy of the injured hemisphere but also impairment of that on the side opposite. The latter point was verified by test cases; clinically this fact explains the intellectual impairment that follows an injury to the brain, as both hemispheres suffer during the course of development that follows the injury in young subjects. The atrophy of the cerebral area, particularly when the motor zone is involved, is accompanied by atrophy of the corresponding cerebral peduncle, pons and pyramidal tract, and cerebellar atrophy on the opposite side.

An interesting result was obtained from a simple excision of a piece of the skull and the dura mater; cerebral atrophy followed on the side corresponding to the site of operation. Such atrophy may exist with or without hydrocephalus. The latter seems to depend a good deal on the changes that take place in the dura mater, which is claimed by the author to play an important part in the production of the disease; the dura mater, he says, is richly supplied by a nervous system.

Porencephalus was also induced experimentally, with or without

hydrocephalus. Some animals, on whom alcohol was used in experiments, manifested epileptiform convulsions as a result of the injection of the poison.

Another point of interest is the fact that cranial atrophy was observed to take place on the side where cerebral atrophy was induced; from an anthropological and criminological standpoint this phenomenon has its importance; as is known, the brain is developed from the ectoderm, while the cranium is developed from the mesoderm; the nervous system has, therefore, a marked influence on the growth of the tissues (*Annali di Nevrologia*, Anno XX, Fasc. 1).

THE QUESTION OF PARASYPHILIS. — DR. LEREDDE: in 1882, M. Fournier stirred up the neurologists by the announcement that tabes dorsalis was of syphilitic origin; the Salpetriere physicians were particularly opposed to this new idea; but it gained ground as time went on, and M. Fournier's advice to give anti-syphilitic treatment for this disease, in its early stages or during its course, was generally accepted. Dr. Fournier has since grouped as *para-syphilitic* diseases, general paralysis, tabes dorsalis and other diseases, which occur in syphilitic subjects; he stated that these diseases were of syphilitic origin, but that their nature was not syphilitic. M. Fournier has confounded under the term parasypilitic a group of various diseases, which happen to take place in a syphilitic subject, without having any special relation to syphilis, and other diseases, of purely syphilitic origin, but highly resistant to syphilitic treatment. This grouping would be out of place were the antisyphilitic treatment administered to the general paralytic and the one suffering from tabes dorsalis. As a rule, the treatment is instituted entirely too late in the course of the disease to yield beneficial results. The difficulty in obtaining good results from the treatment is double the one found under ordinary circumstances, as in the kind of patients here considered degeneracy is added to the organic lesions caused by the syphilitic infection. The author has never known of cases of general paralysis and tabes that have been treated systematically and during a long number of years with anti-syphilitic treatment. Good results from this method of treatment can be obtained only when applied early in the course of the disease and when continued during a very long period of time. M. Fournier seems to contradict himself in his statements: discussing my remarks, he recently stated that he had succeeded in curing only two cases of tabes; in 1882, he was energetic in the declaration that tabes could be radically affected by anti-syphilitic treatment. (*Progres Medical*, April 5, 1902).

LA SOCIOLOGIE CRIMINELLE. — Lecture delivered at the University of Lausanne. PROF. NICEFORO: Experience has shown that the struggle against crime with modern laws is a hopeless task; the penal laws must be replaced by a broader science,—that which delves into the causes of criminality and indicates the scientific measures that may prove efficacious in this struggle; this science is new and he calls it criminal sociology. The causes of criminality are triple: 1, the organic and psychological constitution of the individual; 2, social environment, and 3, geographical environment. Physicians and alienists deserve the credit for having shattered the old scholastic notions of crime and for having substituted a scientific basis for the analysis of criminality. The birth of social criminology is due to the development of two sciences,—psychology and psychiatry. The first teaches us that every act of man, whether the act be of exterior or of interior nature, is the necessary resultant of his organic constitution and of his surroundings (social, physical, or others, which exercise their influence on him). The second teaches that the criminal differs from the normal subject in his organic and in his psychological construction. These differences are of pathological nature and are called degeneracy. These truths show that the will power of the criminal should not be considered as the sole responsible factor in the perpetration of crime; also that the morbid factors of his constitution should be here considered. A tabulated schedule of the causes and criterions of criminality is appended to the article (*La Scienza Sociale*).

THE INFLUENCE OF ACUTE DISEASE ON INSANITY. — Dr. D. ED. WARREN: The onset of acute diseases during the course of mental affections is apt to cause either improvement or a cure. Some alienists have suggested, on that ground, that insane cases be inoculated with the poisons of acute diseases; an Italian alienist reported some cases, which he had treated successfully by injecting turpentine hypodermically and thus caused the formation of abscesses. Some writers even suggested the erection of hospitals in malarial districts, in order that the patients might be exposed to the malarial infection; the proposition was based on the improvement that followed such infection by accident, in seven cases out of twenty-four. The author reports four of his own cases, in which he traces recovery to the action caused by acute diseases. He supposes that the toxic elements of the respective diseases probably act on the toxic elements in the blood found during the course of the various forms of mental diseases. (*Brooklyn Medical Journal*, April, 1902).

DISTURBANCES OF HEARING AND SPEECH OF HYSTERICAL NATURE.—DR. SHEPTELICH-KHERZESKO: An adult man, negative heredity, but a brother, had had an attack of hysterical aphasia subsequent to a fright. The patient suddenly lost his power of speech, after a fright caused by an imaginary vision of an old man in the dark. The hearing was lost first and the speech afterwards. There was some disturbance of the general sensibility in the beginning of the disease, but the sensibility was normal in and around the auditory canals. Cataplectic phenomena were marked. The patient could make himself understood through writing and his intelligence seemed to be perfectly normal, but he could not hear any sounds nor could he pronounce any word. Hypnotism was tried, but the results were negative. Dr. Joire's method was tried: The fingers were placed on the auditory canal and kept in place some two minutes, when the brain is supposed to have had ample time to perceive the sensation of contact; then, the fingers were suddenly withdrawn. In Dr. Joire's cases this method was followed by success; here, however, some method would have been necessary which would have impressed the patient as being miraculous, considering his deep superstitious beliefs. (*Rousski Medizinski Vestnik*, March 1, 1902).

AN ADDITIONAL "PHOBIA."—DR. P. P. SCHAFF-RANOV: The new "phobia" consists of obsessional nose-bleed. The patient is a young and intellectual man, with a marked heredity of insanity. The patient himself has not shown any mental disturbances, but some six years ago he became subject to nose-bleeds, which were generally preceded by some vaso-motor disturbances (reddening and pallor of the face, slight chills and general malaise); he also "feared" that he would have bleeding from the nose. He soon noticed that whenever he happened to forget his handkerchief home or whenever he least desired to have bleeding from the nose, the accident took place without fail. When attending a lecture at the University, the mere thought of that fear was sufficient to bring on bleeding from the nose. He entered a store and thoughtlessly put his hand in his pocket; he found that he had forgotten to provide himself with a handkerchief. As soon as he had realized this, he immediately had profuse bleeding from the nose. The true obsessional trait is rather the fear, the author says, than the bleeding. (*Russki Medizinski Vestnik*, Dec., 1901.)

CEREBRAL LOCALIZATION.—M. LABORD: Excitation within the limits of the Rolandic zone produces convulsive move-

ments on the opposite side; when the excitation is caused outside this region, however, it spreads in the cortical substance and causes epileptic phenomena to take place. From this experiment it seems that an epileptiform attack does not necessarily correspond to an excitation in the Rolandic region; that an excitation in a cerebral region distant from the Rolandic is also apt to cause such convulsions. Finally, there seems to be some suggestive idea, in this connection, of the supplementary action of the Rolandic areas by some other cerebral areas. From a clinical standpoint the fact is most confusing, as it becomes impossible to make an absolute medical or surgical diagnosis under all circumstances. The author had five cases of the nature here considered. (*Progres Med.*, No. 47, 1901).

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THE INFLUENCE OF THE CENTRAL NERVOUS SYSTEM ON BIO-CHEMICAL CHANGES. DR. E. A. AUDENINO: Excision of parts of the prefrontal lobe causes a diminution of secretion of nitrogenous elements in the urine; the phosphates, especially the alkaline, may even disappear entirely from the urine. Extirpation of parts from the occipital and parietal lobes seem to give different results: 1, there is no noticeable change in the quantity of secreted nitrogen; 2, there is no diminution in the quantity of secreted phosphates; on the contrary, in dogs, there seems rather to be a slight augmentation in the secretion of that substance; 3, there is no proportionate diminution in the secreted phosphates. (*Giornale della R. Ac. di Medicina di Torino*, Jan., 1902).

CONTRIBUTION TO THE STUDY OF PSYCHOSES IN CHILDREN.— DR. MORIZ INFELD: The psychoses in children under 13 years of age occur in about 10 per cent. of the total number of cases. The acute manifestations are most frequent in children, particularly when the acute infectious diseases are the exciting agents of the various forms of psychoses proper to the above mentioned age. (*Jahrbuecher fuer Psychiatrie und Neurologie*, 1902).

ON THE QUESTION OF THE SIGNIFICANCE OF REMISSIONS DURING THE COURSE OF INDIVIDUAL FORMS OF ACUTE PSYCHOSES.— DR. ALFRED FUCHS: Three groups of exhaustion psychoses considered in this paper have either an acute or a remittent course; the remittent form is the gravest of the two; it is more often found among those subject to morbid heredity; the obscure forms of relapses

during the course of exhaustion psychoses are more frequently found among women than among men; among women, the remittance is probably due to periodic ovulation. (*Jahrbuecher fuer Psychiatrie und Neurologie*, 1902).

ON A CASE OF CONGENITAL PORENCEPHALUS, IN WHICH THE PORENCEPHALIC AREA CORRESPONDED TO THE AREA OF DISTRIBUTION OF THE LEFT MIDDLE CEREBRAL ARTERY.—Dr. D. A. Shirres concludes his study of a case of porencephalus as follows:

The mother of the patient had a fright while pregnant with the patient 8 months. Threatened abortion was the result, but the child was born apparently normal, at full term. Rigidity and paresis on right side was noticed about the second week after birth. General backwardness of child in walking and talking. At the age of twenty she was apparently a normal woman. Married twice, no family. At about the age of sixty, deterioration of mental faculties began to show itself. Never had any history of fits of any kind. Had kyphotic curvature of dorsal vertebræ with slight dragging of right foot. Spasticity of little account, save in arm and hand of right side.

THE PORENCEPHALIC CAVITY AND HEMISPHERES.—A probable primary lesion of middle cerebral artery (thrombosis), the occlusion taking place immediately after the perforating arteries from the basal ganglia are given off. This lesion had apparently occurred in the later months of foetal existence, and was due to rupture of foetal vessels in the placenta. The lesion was followed by atrophy and destruction of a large section of the cerebral cortex on the left side in an area supplied by the middle cerebral artery. The destruction was more extensive than was apparent at first sight, the cavity being in part filled in by the puckering and collapse of the surrounding tissue. The author is not inclined to believe that the atrophy of the vessels was secondary to the destruction of the cortex.

2. The porencephalic cavity thus found did not communicate with the lateral ventricles, but was bounded externally by the arachnoid, while the pia lined the sides and bottom of the cavity.

3. There existed a general diffuse atrophy of the cerebral convolutions of the left side (which were not simplified) with a marked lessening of the large pyramidal cells and of the projection system of fibres, especially so in what remained of the motor region; the association fibres were apparently normal.

4. The right hemisphere was normal in shape and structure with an increase in the large motor cells.

5. Symmetrical condition of the bones of the skull.

6. Dura not thickened or hardened.

7. The corpus callosum apparently normal in size.

BASAL NUCLEI.—8. The left caudate and lenticular nuclei normal in size and fully equal to their fellows of the opposite side.

9. General atrophy of the left optic thalamus, there being marked lessening in the number of cell bodies and of nerve fibres of the different nuclei present in that body.

10. Marked atrophy and absence of the middle and posterior portion of the internal capsule.

SECOND NERVE.—11. The left superior quadrigeminal body less in size than the one on the right.

- 12. Left inferior quadrigeminal body presented marked atrophy.
- 13. The brachium of the left inferior quadrigeminal body showed an almost complete absence of fibres.

14. The left corpus geniculatum mediale absent.

15. The left optic tract markedly atrophied.

16. The left optic nerve was found smaller in calibre than the right, certain bundles in the inferior portion being very markedly atrophied, and there was present an increased amount of glial tissue between all the bundles. The right optic nerve showed atrophy of its central bundles with a general increase of glial tissue.

17. The red nucleus on the left side was markedly smaller than that on the right.

CEREBELLUM.—18. The left superior cerebellar peduncle above the decussation was smaller than the right, and the right was smaller in the pontal region.

19. Atrophy of the right dentate nucleus and right cerebellar hemisphere with lessening in the number of Purkinje cells, projection fibres and molecular layer; association fibres normal.

20. Marked atrophy of the lingula on the right side.

PES.—21. In the basis pedunculi there was well marked atrophy of the pyramidal motor fibres of the left side.

22. Atrophy of the fibres of the fronto-cerebro-cortico-pontal path in the medial portion of the basis pedunculi. The fibres of the temporo-cortico-cerebro-pontal path atrophied in the lateral portion of the crus, and though not quite wanting here, wholly wanting in the upper part of the pons.

23. Locus niger on both sides seemed normal.

PONS.—24. Left middle and inferior cerebellar peduncles were much larger than those on the right.

25. A large number of pontal nuclei on the left side were absent, their places being taken by glial tissue.

26. The posterior longitudinal fasciculus is smaller on the left side.

27. The left olive was much contorted, but otherwise appeared normal.

28. The nucleus of origin of all cranial nerves on the floor of the fourth ventricle appeared normal.

29. The external arcuate fibres of both sides were well developed: marked hypertrophy of the arcuate nucleus on the left side.

FILLET.—30. Slight atrophy of right nucleus cuneatus, but more so of its internal nucleus; nucleus gracilis distinctly atrophied.

31. Marked lessening of internal arcuate fibres of the right side.

32. Marked lessening in size of the interolivary stratum of left side.

33. The lateral internal arcuate fibres were normal on both sides.

34. Marked contraction with sclerosis of the inner field of Flechsig on the left side seen throughout the medulla.

35. The left lateral fillet was markedly sclerosed and smaller than the right both in size and in number of nerve fibres present.

36. The nucleus of the lateral fillet on left side was absent.

37. There was a sclerosis and absence of the nerve fibres forming the most medial portion of the left median fillet (motor). There was further a general sclerosis affecting the lateral part of the left mesial fillet, with associated lessening in size and number of the component fibres.

MEDULLA.—38. As under normal conditions, the lemniscus increased in size as it progressed upwards, owing to an accession of fibres from the sensory nuclei of the medulla.

39. In the left pyramidal tract in the medulla only a trace of fibres were to be seen.

40. In the right side of the pons and medulla there was present a sclerosed tract in the area usually occupied by Gowers' ascending fasciculus.

CORD.—41. The cross pyramidal tract situated on the right side of the spinal cord was absent. Notwithstanding the long continuance of the condition there were still recognizable a most marked sclerosis in the region of the absent fibres of this tract.

42. The crossed pyramidal tract on the left side, while showing abundant, well formed fibres, showed also some diffuse sclerosis.

43. The left pyramidal tract on the left side was found almost completely absent.

44. Goll and Burdach's columns normal.

GREY MATTER.—45. Clark's vesicular column normal.

46. The anterior horn (grey matter) of the right side was altered both in size and shape; the cell bodies were more numerous than in the left horns, but were of a lower type.

47. One group of cell bodies, the lateral and posterior external, were absent.

48. There was an abnormal arrangement of the nuclei of the back muscles (commissural group).

49. Degenerate tracts in the antero-lateral region of the cord on both sides, most marked in upper cervical region.

50. In this case we have a large number of superimposed neurones affected, numerically greater than in other cases described. This may be due to the age the patient attained (seventy-six). (*Studies from the Royal Victoria Hospital, Montreal, Vol. 1, No. 2*).

ALCOHOLISM AND CRIME. HOW WE SHOULD DEAL WITH THE CRIMINAL ALCOHOLIC.—DR. HEINRICH STERN: At least 70 per cent, of all perpetrated crimes are directly or indirectly attributable to alcoholism. The most deplorable result of parental alcoholism is the birth of morbid offspring. According to our present laws, the habitual or periodic drunkard who has committed a slight offence is imprisoned in a penitentiary or in a workhouse, where he is in close proximity and contact with criminals. This must be detrimental to such subjects. Prison statistics prove that the more frequently an alcoholic is incarcerated, the less capable of reformation does he become. The prison is the wrong place for the inebriate offender, as he is neither treated appropriately nor does he benefit morally in these institutions. Every police court should have an efficient medical officer, whose duty it should be to determine whether a given prisoner is an alcoholic or not. The alcoholic subjects should be cared for in specially constructed institutions, in the country, where the open air and suitable occupations would contribute to a speedy recovery and restoration of the subjects to a self supporting occupation. Part of the revenue derived from the liquor tax should be appropriated to defray the expenses of the penal institutions, as the subjects who fill the latter are the main source of the liquor tax income. The establishment of asylums for criminal alcoholists would cause the transfer of at least half the inmates from the penitentiaries. (*American Medicine, Feb. 1, 1902*.)

THE ENCOURAGEMENT OF TEMPERANCE.—The French Governor-director of railroads has written to the different temperance societies that all the government roads have agreed to discharge all employees who persist in using spirits and wine while on duty; that all persons who continue to drink shall be dropped from the pension rolls of the company, and will not participate in the endowment funds in case of an accident. All restaurants on the road are forbidden to sell spirits to the workmen. In the United States, Rule 207, of the Union Pacific, prohibits employees patronizing saloons; it is said that this has ruined twenty-five saloon-keepers. The rule has been in force for four months; special agents are employed to report violations and offenders are dropped regardless of previous standing. Some saloons have moved and three gambling houses have closed (*American Medicine*, March 29, 1902.)

VAGABONDAGE OF CHILDREN; MEASURE AGAINST IT.—The general Court of Rouen has issued orders to policemen to bring to the respective police stations children who wander about in the streets during school hours. The parents are then notified and asked to come and give their children's histories; the latter are systematically filed and can be helpful in the future, if occasion brings these subjects again to legal notice. The parents are then allowed to take home their children, after some admonition is given regarding the proper care of their offspring. M. Martin, Prefet of the Lower Seine, has issued circulars to the mayors of his Department of the Seine, requesting them to follow in the footsteps of the Rouen authorities in regard to the handling of juvenile street-wanderers (*Progres Medical*, May 10, 1902).

METHODS AND CRITERIA FOR THE RE-EDUCATION OF THE DEMENTS.—Dr. C. Colucci devoted some space to the study of the education of the dement and shows the practicability of his method. The dement should be taken in hand before he loses all mental responsiveness; he should be taught to exercise his intellect in whatever direction he is best inclined; manual work and amusements should make part of this re-education. (*Annali di Neurologia*, Anno XX, fasc. 1).

ERRATUM: Vol. II, No. 4, page 170, 2d paragraph, 12th line: eagle (?) should read guinea-pig.

BOOK REVIEWS.

THE MENTAL FUNCTIONS OF THE BRAIN.—An Investigation into their Localization in Health and Disease. BERNARD HOLLANDER, M. D., M. R. C. S., L. R. C. P. Illustrated with the Clinical Records of Eight Hundred Cases of Localised Brain Derangements and with several Plates. G. P. Putnam's Sons, New York and London, 1901.—In these days of

obscure knowledge of what constitutes the mind and its elements, it is rather interesting to come across a work which claims that the various mental affections are accompanied by lesions of specific cerebral centres. As is indicated in the title of this work, eight hundred clinical cases are cited as demonstrations of the theory of mental localization in the brain. Thus, mania, melancholia and other clinical varieties of mental derangement are said to be caused by respective cerebral lesions; although the work is not irreproachable in all respects, one finds there a rich source of suggestive ideas for clinical research in psychiatry. Even the statements that seem to be fundamentally wrong from the standpoint of our present knowledge of cerebral anatomo-pathology are helpful in the linking of isolated clinical phenomena and in the construction of schemas for investigation of mental medicine. General paralysis, for instance, is said to be a disease of the intellect, and the early affection of the frontal lobes is considered as being a natural outcome; melancholia, however, is said to be an emotional disease, and the freedom of the frontal lobes from any affection during the course of this malady is said to be a natural outcome; the angular and supramarginal gyri are said to be the centres affected in this disease, as these gyri are the centres of emotion. Although this theory is seductive, Professor Tschisch, of Dorpat, gives a more tenable explanation of the early involvement of the prefrontal lobes in general paralysis, which is called here a disease of the intellect. The Russian Professor holds that general paralysis is a disease caused by a generalized infection of the entire system; that every tissue in the body is equally involved; that the tissues of highest development are affected earliest; this seems to be the fate of tissues of late development; consequently, the prefrontal lobes are early affected in general paralysis because of purely anatomical reasons. A similar trend of reasoning might also explain the involvement of the frontal lobes in delirious mania. Dr. Hollander claims that such an involvement exists in the morbid entity known as "acute mania." If we combine this statement with that of other author's who claim that this disease is due to infection, the frontal-lobe pathology can be accounted for in a manner similar to that given by Professor Tschisch, as above explained. Given Dr. Hollander's statement that melancholia is due to a focal lesion in the brain, a long chain of reasoning may, perhaps, lead us to the discovery of cause and effect. It does not seem logical, however, to accept his view that melancholia is an emotional disease. Mental depression, as we know it in clinical work, is rather a result or an accompaniment of impaired intellectual vigor; under these conditions exagger-

ated emotion is rather a result than it is a cause: a vigorous intellect is incompatible with demential constructions of persecution, etc. The author seems to have successfully carried out his plan of presenting in his work a source of suggestions for further study of psychiatry in its relation to cerebral function. The volume has 507 pages and is neatly and handsomely published.

DR. FELIX AUGHIER. CONTRIBUTION A L'ETUDE DES RAPPORTS DE LA PARALYSIE GENERALE PROGRESSIVE ET DE LA DEGENERESCENCE. — Thèse de Bordeaux, 1901.—Some authors regard degeneracy as the origin of general paralysis, while others consider this disease as being of cerebro-congestive nature. The author investigated the question regarding the relation of general paralysis to degeneracy; he found that the general paralytic was not characterized by stigmata of degeneracy; he is rather like a normal person in regard to freedom from these stigmata. General paralysis seldom sets in in the degenerate; when this is the case,—the disease is not as typical in nature as it is when affecting the individual who was normal previous to the onset of the affection.

DR. STEPHANE PALLUT. DE LA SORTIE PREMATUREE DES ALIENES. — Thèse de Bordeaux, 1901.—There exists a popular belief that it is easy to gain admittance as a patient to hospitals for insane; a large number of crimes committed by the insane is due to the fact that they are not committed to hospitals early enough and that they are taken home by their friends too early,—before recovery has taken place. Popular ignorance is the cause of claims for premature discharges of insane patients. Other causes are overcrowding of the hospitals and lack of facilities for maintaining the patients. The radical remedy would be a thorough and ample provision of agricultural facilities and ample quarters for the housing of the patients.

DR. LOUIS-HENRI-GERMAIN GRIMAUD. DE LA NEURASTHENIE SENILE. — Thèse de Bordeaux, 1901.—Besides the neurasthenia of adult age and that of childhood there exists a true senile variety of the disease; arterio-sclerosis is a predominant cause in this variety of the malady; the disease is not incurable, unless it is complicated by intercurrent diseases; in some cases it may become complicated by cerebral disintegration and dementia.

BOOKS AND PAMPHLETS RECEIVED.

Dr. Serafino Biffi. OPERE COMPLETE. Vol I., FISIOLOGIA E FISIOPATOLOGIA SPERIMENTALE, 1902, Ulrico Hoepli, Milano.

Dr. Serafino Biffi. Vol. III., PSICHIARIA (Tecnica manicomiale), 1902, Ulrico Hoepli, Milano.

Monographies Cliniques No. 30, July 23, 1902. *M. Henri Dominici.* LE GANGLION LYMPHATIQUE, Masson et Cie, Paris.

N. Vaschide and Cl. Vurpas. DI ALCUNE ATTITUDINI CARATTERISTICHE D'INTROSPEZIONE SOMATICA PATHOLOGICA.

Dr. C. E. Mariani. PSICOLOGIA DELLO ZINGARO.

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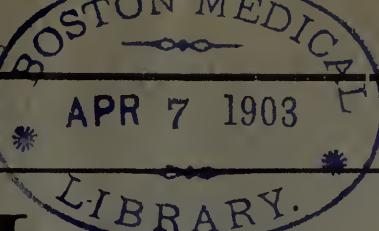
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THE JOURNAL OF MENTAL PATHOLOGY.

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Nos. 2-3.

ON THE UTILITY OF LUMBAR PUNCTURE IN THE DIAGNOSIS OF GENERAL PARALYSIS.*

By A. JOFFROY, Professor, *Faculty of Medicine, Paris,*
and

E. MERCIER, Chef de Clinique, *Faculty of Paris.*

The use of the lumbar puncture, practiced at the Clinic of Mental Disease, Ste-Anne Asylum, during the last year, has enabled us in many instances to make a positive diagnosis of general paralysis in doubtful cases; in some instances it would even have been impossible to make a positive diagnosis without the aid of this method of investigation.

In the lectures delivered at the Clinic, at Ste-Anne, during the year 1901-1902, the difficult subject of cytological examination of the cerebro-spinal fluid was treated of and the value of this examination was pointed out. These lectures are to form a part of a treatise on the application of lumbar punctures in the diagnosis of general paralysis. It seems to us useful to remark even now that lumbar punctures are most fruitful in results and that this method should be made familiar as much as possible.

The consideration of the diagnostic value of this method is not merely theoretical; on the contrary, it is of most practical importance, dealing with clinical facts observed by us; every alienist can observe similar facts.

In order to justify our desire to attract attention to this subject we refer the reader to the report on general paralysis, by M. Arnaud, read at the Congress of Toulouse, in 1897. In the report

* Read at the Congress of Alienists and Neurologists of France and the French Speaking Countries, held at Grenoble, August, 1902.

itself, as well as in the discussion that took place, the following was pointed out: there was some difficulty in some cases and absolute impossibility in others in utilizing this method of diagnosis.

In some cases of this affection there are physical signs of unquestionable value; in some cases the mental signs are such that the diagnosis cannot be doubted. In the beginning of the disease, however, all these signs may be wanting or else not easily recognizable; yet the making of the diagnosis of this affection at the earliest possible moment is of the utmost value.

At the Congress above mentioned, much time was devoted to the discussion of what constituted the earliest and most constant symptom of general paralysis. To-day we think that the earliest and most constant sign of general paralysis consists of the presence of an abnormal quantity of the white element in the cerebro-spinal fluid; the discovery of this sign has radically transformed the possibility of making an early diagnosis of general paralysis.

Whenever general paralysis is suspected, one should, we think, resort to the aid furnished by a lumbar puncture. If the white elements are found to be not augmented in number, the suspicion of general paralysis must be dropped at once. The diagnosis may be made positively, however, if the quantity of these elements is augmented above the normal; when this diagnosis is made, however, the existence of other affections of the nervous system must be excluded.

These two facts have been pointed out in the results obtained by various authors. Our own results encourage us to speak affirmatively, as we do, particularly because our experiments cover a period of over one year; our statistics are, therefore, supported by a sufficiently large number of cases.

Advisedly, we omit citing any quantitative formulæ regarding the leucocytes, although we have found them applicable in many instances. We do not wish to complicate the question and shall limit ourselves to the statement that from the practical psychiatric standpoint all importance is attached to the total number of leucocytes.

It is absolutely indispensable, whenever possible, to ascertain accurately whether the quantity of the white elements is really augmented above that of the normal. We strongly advise making a numerical valuation of the white blood corpuscles found in the liquid. Although this numerical method is only approximate and varies with every handling, the obtained figures are yet comparable among themselves and are superior to the simple examination of the colored preparations; this latter method should not be belittled,

however, and should always be practiced in conjunction with the one above mentioned.

Regarding the numerical value of the leucocytes, we consider them as being above the normal when they surpass 5 units per cubic millimeter in a specimen of the cerebro-spinal fluid.

In the normal and in the ordinary insane subjects, the number of the leucocytes is generally one of the two comprised between 0 and 2. When the figure found vacillates between 2 and 5 in the cubic millimeter we consider the case as being a doubtful one and we generally wait a few days and make a new lumbar puncture.

The figures given above relate to the results obtained from one hundred and twenty punctures practiced on ninety-one different patients.

The following are the results obtained in our cases :

We made seventy lumbar punctures on forty-eight different paralytics. In seventeen of these we found a considerable augmentation of the white corpuscles, although we made no numerical calculation of these elements.

Of fifty-three cases in which the corpuscles were counted, the following number of white corpuscles was found per cubic millimeter :

In four cases they varied between 0 and 5 ; in eight cases they numbered between 5 and 10 ; in 13 cases they varied between 10 and 20 ; in eighteen they varied between 20 and 50 ; in eight they numbered between 50 and 100 ; in one they numbered between 100 and 200 and, finally, in one case the leucocytes numbered 204 per cubic millimeter.

As is seen, the number of white blood corpuscles is considerably augmented in the majority of cases ; only in four out of seventy punctures we find a very small number of white corpuscles. From a practical standpoint, however, three of these punctures should be excluded (one in one case and two in another). Both of these cases presented characteristic signs of speech and Argyll-Robertson pupils and can thus be classed as being general paralytics ; but the long period of evolution of their disease (over seven years in one case and over twelve years in the other) makes us class them in a special category, which we shall consider elsewhere. We shall only remark that there are cases with Argyll-Robertson signs without presenting an augmentation of the number of leucocytes ; this opinion is in contradiction to that recently given by Widal.

Only the fourth case can be cited unconditionally as an example of general paralysis with absence of hyperleucocytosis. This patient died in a condition of paralytic marasmus, about one year after the onset of the disease. A puncture was made a few days

before death, and, unfortunately, the operation was not repeated.

Thus, sixty-six out of seventy punctures made on forty-eight general paralytics showed a notable augmentation of the white blood corpuscles in the cerebro-spinal fluid. The other cases, whatever the period of evolution was, presented an abundance of lymphocytes.

We have seen this augmentation precede the manifestation of disturbance of speech and that of inequality of the pupils; in a way, this augmentation seems to us to constitute a far superior symptom to all other physical symptoms, in so far as its constancy is concerned.

Besides these cases, we found four cases which presented an augmentation of the white elements up to 5 per cubic millimeter; these were cases of tabes dorsalis with mental disturbances. We also found the leucocytosis abnormal in a case of syphilitic meningo-myelitis with Argyll-Robertson signs. In the other cases the quantity of the leucocytes was normal.

Thus, in ten cases of dementia præcox we found the figures as follows: four times the index was negative, in five instances the number of leucocytes was included between 0 and 1 and once between 1 and 2.

Similar results were obtained in three cases of mental debility with delirium, the number being included between 0 and 1.

In a case of maniacal excitement of prolonged duration we found the following number of leucocytes, as explained, in the fluid obtained at three different punctures: 3.5 at the first, 1.5 at the second and 2 at the third.

One case of acute mania, during the course of pulmonary tuberculosis, gave us negative results.

In three cases of mental confusion we did not find any abnormal numbers of leucocytes in the cerebro-spinal fluid.

In the case of cerebral syphilis, which was cured of the syphilis, but which presented a marked intellectual enfeeblement, the number of leucocytes was 2 per cubic millimeter.

We found no augmentation of the white corpuscles in a case of focal cerebral softening, nor in one of hydrocephalus.

We made an examination in only one epileptic, and our results were negative; this result seems to be in accordance with those of other statistics.

We also found a normal proportion of leucocytes in a case of epileptiform attacks of albuminuric origin.

Finally, we made seventeen punctures in fourteen alcoholic subjects, and in all cases the number of leucocytes varied between

0 and 2 per cubic millimeter. This result indicates that alcoholism does not produce any modification in the number of white corpuscles in the cerebro-spinal fluid.

We wish to remark that although MM. Dufour and Duflos have each published a case of hyperleucocytosis in the cerebro-spinal fluid in a chronic alcoholic subject, we have not been able to verify their results. We examined two cases of alcoholism,—typical cases of polyneuritic psychoses of Korsakoff, and we did not find any hyperleucocytosis in their cerebro-spinal fluid. Besides, four of our cases could easily be classed as chronic alcoholists.

To sum up the results of the experiments by others as well as those made by ourselves, we can say, at least, that lymphocytosis is very rare in occurrence in chronic alcoholism with meningitis; nothing points towards its existence in the early stages of alcoholic intoxication.

Our statistics fully justify what we have said above, regarding the presence of hyperleucocytosis: When the quantity of white blood corpuscles is not augmented, one is justified in rejecting the supposition of the existence of general paralysis; if, on the contrary, the quantity is above the normal and if no other affection of the nervous system exists to explain this presence, one is justified in diagnosing general paralysis.

These two conditions are valuable aids in cases of general paralysis that are difficult to diagnose by the usual method.

The diagnostic value of lumbar punctures becomes much more precise when the leucocytosis is considered not only in its crude relation to general paralysis as furnished by the statistical data, but also in its relation to the respective ages of the patients.

Thus, we have found that the number of the white corpuscles is much higher during the early stages of general paralysis, at a period when it is most difficult to make a definite diagnosis, and when the cytodiagnosis is most valuable.

Everything in our experiments points to the fact that the number of white blood corpuscles cannot be normal in the general paralytic, during the first stage of the disease; this warrants the clinician's making a negative diagnosis when the examination of the cerebro-spinal fluid of a suspected general paralytic shows the number of leucocytes to be normal.

Our experiments were utilized mostly for the purpose of making a differential diagnosis between alcoholism and general paralysis; and the ulterior evolution of the respective diseases only confirmed the accuracy and value of the method of diagnosis employed.

Objection may be made to our statements on the ground of authentic experiments showing that chronic alcoholism may be

accompanied by an increased number of lymphocytes in the cerebro-spinal fluid.

We wish to reply, firstly, that our method loses in value only in cases of positive examinations; secondly, that in the above referred to experiments the cases examined were those of alcoholic meningitis, that is to say, cases of a particular form of alcoholism, incurable in nature, and the diagnosis of which is not of as much importance as is that of curable forms.

The special interest attached to the differential diagnosis between general paralysis and alcoholism applies to sub-acute forms of alcoholism with transitory disturbances of speech and, sometimes, inequality of the pupils, on the one hand, and to the numerous cases of general paralysis which assume the form of sub-acute alcoholism, on the other hand.

Arnaud stated, in his report to the Congress held at Toulouse, that the wisest method of diagnosing general paralysis was oftenest that of waiting for the evolution of the disease. With the method under consideration, however, we are enabled to-day to do better, as the diagnosis by means of the lumbar puncture seems to be absolute in either of the two above mentioned cases.

In 1901, one of us reported such a difficult case to the Medico-Psychological Society, at the meeting of May 20. The subject was one of chronic alcoholism, non-syphilitic, in a sub-acute state. He was admitted to the Ste-Anne Asylum with the following diagnosis: "Chronic alcoholism, hallucinations, excitation, continuous loquaciousness and extravagant acts."

The hallucinations and the delirium disappeared on the day following the date of admission and the patient remained in a condition of mental confusion and obnubilation. The following days were characterized by a general amelioration, but the patient presented amnesia regarding all events that preceded the date of his confinement to the asylum.

A fortnight later, the obnubilation had disappeared and the following condition was noted: Slight intellectual enfeeblement; tremor of the fingers; speech free from disturbance; inequality of the pupils, that could be explained by a slight corneal leucoma and, finally, the light reflexes were normal.

To sum up our case,—we could only suspect the presence of general paralysis; a lumbar puncture with an examination of the cerebro-spinal fluid showed us, however, that the number of white blood corpuscles was augmented. This incident enabled us to make a positive diagnosis of general paralysis, even in the absence of all usual signs on which such a diagnosis is generally based. In fact, we have had occasion to verify the accuracy of our diagnosis;

after a transitory period of intermission, a remission took place bearing all the characteristics of the disease.

In other cases, on the contrary, although apparently analogous to the preceding one, lumbar punctures showed the number of white blood corpuscles to be normal, thus enabling us to give a favorable prognosis after the very first examination of the cerebro-spinal fluid; we had occasion, later on, to satisfy ourselves that we had not been mistaken in the cases.

General paralysis may simulate the various forms of psychoses. It often happens that one finds much difficulty in differentiating this disease in its early development from an attack of mania or from that of melancholia. An examination of the cerebro-spinal fluid can help decide such a difficult question.

As an instance we cite the following case: We had under observation a man, 47 years of age, who seemed to be in a normal condition, until four months before his admission to the asylum. At that time he said that he noticed a transformation in his personality. He was of correct habits and never indulged in alcoholic drinks up to that time; his usual habits suddenly changed, he commenced to indulge in alcoholic drinks and showed marked sexual intemperance. He committed some indelicate acts and was even sentenced to imprisonment for some petty thefts.

The patient's condition on admission was thus characterized: mental excitation, marked loquaciousness, euphoria and multiple vast projects. There was no disturbance of speech; no mental disturbance; the pupils were somewhat deformed and they became irregular in shape, slightly unequal in size, a short while after the admission of the patient to the wards.

The unimpaired mental condition and particularly the integrity of the memory were not in favor of the diagnosis of general paralysis; but, on the other hand, the inequality of the pupils, the multiple and grandiose projects and the odd conduct of the patient suggested the possibility that the patient was suffering from general paralysis.

We made several lumbar punctures; as the examination of the cerebro-spinal fluid thus obtained was negative, we were enabled to eliminate the diagnosis of general paralysis. And, indeed, the evolution of the disease confirmed the truth of our diagnosis.

We cite here one more case, that was similar to the preceding one by its onset. Although the intellect was unaltered, the memory intact, the speech and writing normal, the pupils alone presenting some slight inequality, we made a diagnosis of general paralysis; this diagnosis was made regardless of a well defined period of intermission. When a lumbar puncture was made, the confir-

mation of our diagnosis was most manifest, as we found some fifty white blood corpuscles per cubic millimeter.

One of the finest differential diagnoses known to clinicians is that between general paralysis and mental confusion. We are pleased, therefore, to state that we were enabled to differentiate between these two forms of disease by means of a lumbar puncture and the examination of the cerebro-spinal fluid.

We have found the cytodiagnosis of great value in differentiating aphasia due to a common focal lesion of the brain from general paralysis. In such instances we resorted to the use of the lumbar puncture and made a diagnosis of general paralysis in cases which showed an increased number of leucocytes in the cerebro-spinal fluid; the diagnosis of aphasia, on the contrary, was made in those cases which showed an absence of leucocytosis. The eventual development of the respective diseases only confirmed the truth of our diagnoses.

We could multiply examples of cases in which the cytodiagnosis is invaluable, but we prefer now to point out some cases in which this mode of diagnosis can be of no value at all.

It is of the utmost importance to exclude the possibility of other affections of the nervous system which might account for an increased number of the leucocytes. As an example we wish to cite the case of an insane subject, whose cerebro-spinal fluid contained an increased number of leucocytes although he was not suffering from general paralysis.

The subject was a chronic syphilitic, forty years of age. He was brought to our wards on account of an intense maniacal excitation; he presented, besides, Argyll-Robertson signs and those of syphilitic meningo-encephalitis; all these signs as well as the maniacal excitation disappeared under the influence of specific treatment.*

One finds, not infrequently, subjects with tabes dorsalis suffering at the same time from mental troubles; in such cases it is often important to determine whether the mental manifestations are curable or, on the other hand, whether they are symptomatic of

* The lumbar puncture does not seem to us to resolve the difficulty of making a diagnosis in cases giving reason for hesitation between the diagnosis of cerebral syphilis and that of general paralysis in its first stages; as is known, there is an increased number of white blood corpuscles in the cerebro-spinal fluid in either of these instances. M. Nageotte, particularly, has insisted on the constant presence of lymphocytosis in cerebral syphilis. This fact may be true in the beginning of the affection, but this sign may disappear eventually. We have verified this statement in one of our cases: for some years, the patient has been subject to cerebral syphilis, but his cerebro-spinal fluid does not present any abnormal leucocytosis.

lesions characterizing general paralysis. Under these conditions the lumbar puncture is valueless, because in either of the above cited instances the number of white corpuscles is augmented in the cerebro-spinal fluid.

We do not wish to detain the Congress any longer by the presentation of more details of our report; we propose to treat of this subject at a future time. We only wished to bring to notice the results of our experiments on lumbar punctures, during a period of some fifteen months; we wished to bring to the notice of this Congress the importance played by the lumbar puncture in the great question of the diagnosis of general paralysis.

ON THE CUTANEOUS TEMPERATURE IN THE GENERAL PARALYTICS.

By N. VASCHIDE, Chef des Travaux,, *Laboratory Experimental Psychology, School of Higher Studies*, and
H. MEUNIER, Interne, *Asylums of the Seine (Ste.-Anne)*.

The question of local surface temperature is one little known; the scanty experimental researches that have been published on the subject are accepted with some adverse criticism. Yet the study of this subject is most valuable and the psycho-physiologist as well as the clinician would benefit by the progress in this line of work. The main difficulty in experimenting with the surface thermometer lies in the imperfection of the instruments used for this purpose; when once obtained, however, the index figures, although not absolute in value, are yet constant and, consequently, useful for the purpose of comparison.

In our investigations of the thermic disturbances in the general paralytics we made use of the method of direct thermometric local measurement known in the laboratories under the names of Germain-Sée, Peter-Lépine, etc.

The history of the local thermometric technique is rather meager. The local mercury thermometer, the thermo-electric needle and the Germain-Sée spiral thermometer may be said to complete the list of instruments in use for these experiments. The thermometric scale ranges between 30 and 42 degrees Centigrade and every division is subdivided into ten degrees. A glass bell is used as a handle to the instrument, thus preventing the temperature of the experimenter's fingers to influence the mercury of the thermometer.

Most of the authors who have worked on this subject have pointed out the great difficulties which accompany the operation. According to Ch. Richet, the studies of this question published by

Leblanc, Couty, and Roemer, are valueless because the technique which they employed was imperfect. Richet thinks, with many other experimentors, that it is impossible to measure correctly the peripheral temperature (1).

According to Quenke (1888), who made a systematic study of the cutaneous temperature, the latter is generally three degrees below the rectal temperature. It is therefore possible to make out a certain constant comparative relation between the obtained temperatures. The same author also found that the skin which covered the muscles was warmer than was that which covered the bones, the tendons and the joints.

Regardless of all these difficulties we succeeded in obtaining the local temperature of thirteen patients; nine of these subjects were general paralytics nearing the second and third stages of their affection; at the time of the experiments they were free from epileptiform and apoplectiform attacks. The patients remained in bed while their temperatures were being taken.

Although the question of vaso-motor disturbances is of great importance in relation to general paralysis there is very little to be found on this subject in technical literature.

As is well known, the vaso-motor disturbances play an important rôle in general paralysis and that apoplectiform and epileptiform attacks are common episodes of the disease. According to Reinhard (2) the phenomena of vascular paralysis,—the immediate consequences of unilateral epileptiform attacks, are accompanied by an elevation of the central temperature to the extent of at least one and one half degrees above the axillary temperatures. This author's work on the temperature in general paralysis is the most carefully studied and the most reliable. The following is a quotation from his own publications:

“One of the results of my experiments concerns the difference between the unilateral temperatures of the general and local regions of the ears. As a starting point I chose the well known fact that in hemiplegia the paralyzed part has an elevated temperature at first. I paid a great deal of attention to the difference of the temperatures on both sides in paralytics with unilateral motor disturbances. The results of my researches can be thus summarized: The temperature taken in the axilla is higher on the paralyzed side. I do not venture to affirm that the same is true of the local temperatures, as my experiments are not yet sufficiently numerous to warrant such a conclusion; nevertheless, the small number of experiments concerning this subject leads one to believe in the truth of the above statement. When there is a complete or an incomplete hemiplegia, or partial or extensive unilateral contrac-

tions or spasms, the statement concerning the individual unilateral temperatures holds good.

"I have chosen for my experiments cases in which the motor disturbances have been of long duration, and in which the elevation of the temperature had already disappeared. I cite here three cases to confirm my statements. These patients belong to a series of fifteen cases which I have studied; these cases are interesting from a double point of view; the temperatures were taken during an advanced stage of their disease; this enables one to obtain a definite idea about the form, course and fluctuation of the temperature in general paralysis. I also wish to add that during the experiments the three patients remained in a uniform condition, showing absolutely no irritation."

C. Reinhard also gives the bibliography of the works of the day concerning the question of the temperature in mental diseases. We have not found anything definite, however, concerning the subject under consideration, although we have consulted the works of the leading authors treating of this temperature (3).

As we have been enabled to distinguish the difference of temperature even by the simple contact of the hand we concluded that the vaso-motor disturbances in general paralysis were not transitory episodes, but, on the contrary, invariable signs.

Our results are based on figures obtained by the same experimenter. The thermometer was kept applied to every surface analyzed during a period of twenty minutes. The temperatures of the respective symmetrical parts, right and left, were taken one immediately after the other. In the table are grouped the individual thermometric records and there is recorded the difference between the right and left temperatures. The topography of the parts examined is also indicated.

Our experiments show that the general paralytics present a marked thermic asymmetry as compared with the normal subject; this condition is independent of any convulsive manifestations. This fact has not been brought out distinctly in any previous publications by various authors. Besides, we think that this thermic difference, which is appreciable even by the naked hand, leads us to believe that this manifestation is not a transitory episodic vaso-motor disturbance of general paralysis, but, on the contrary, a fixed symptom.

The differential temperatures between the general paralytics and the other subjects, as brought out in the appended table, are too apparent to require any comment.

We limit our remarks on this question to this short note and we hope to develop the subject some time in the future.

TABLE SHOWING THE LOCAL CUTANEOUS TEMPERATURE IN NINE GENERAL PARALYTICS,
IN ONE IDIOT, IN ONE EPILEPTIC AND IN TWO NORMAL SUBJECTS.

REGION.	LEFT.	RIGHT.	DIFFERENCE.	LEFT.	RIGHT.	DIFFERENCE.	LEFT.	RIGHT.	DIFFERENCE.
Frontal.....	34.7.....	35.1.....	plus 0.8.....	34.5.....	35.2.....	plus 0.7.....	34.....	34.....	0.....
Acromion.....	34.4.....	35.....	plus 0.6.....	34.9.....	34.1.....	minus 0.8.....	31.....	31.2.....	plus 0.2.....
Breast.....	35.7.....	36.4.....	plus 0.7.....	35.1.....	35.....	minus 0.1.....	33.1.....	34.4.....	plus 0.3.....
Hip.....	37.6.....	37.6.....	0.....	36.2.....	36.3.....	plus 0.1.....	35.6.....	34.1.....	minus 1.5.....
Thigh.....	".....	".....	".....	".....	".....	".....	".....	".....	".....
Foot.....	".....	".....	".....	".....	".....	".....	31.2.....	30.8.....	minus 0.4.....
Hand.....	".....	".....	".....	".....	".....	".....	31.8.....	33.9.....	plus 2.1.....
Frontal.....	34.1.....	32.5.....	minus 1.6.....	34.7.....	34.6.....	plus 0.1.....	35.....	34.3.....	plus 0.7.....
Acromion.....	.....	.....	.....	34.9.....	34.6.....	minus 0.3.....	.....	.....	.....
Breast.....	".....	".....	".....	".....	".....	".....	33.5.....	34.6.....	plus 1.6.....
Hip.....	36.1.....	34.6.....	minus 1.5.....	35.4.....	36.1.....	plus 0.7.....	34.8.....	34.1.....	minus 0.7.....
Thigh.....	34.....	34.7.....	minus 0.7.....	.....	.....	.....	32.5.....	32.3.....	minus 0.2.....
Foot.....	.....	.....	.....	.....	.....	.....	".....	.....	.....
Hand.....	.....	.....	.....	.....	.....	.....	35.2.....	36.....	plus 0.8.....

(Continued)

TABLE SHOWING THE LOCAL CUTANEOUS TEMPERATURE IN NINE GENERAL PARALYTICS,
IN ONE IDIOT, IN ONE EPILEPTIC AND IN TWO NORMAL SUBJECTS.
(Continued)

REGION.	LEFT.	RIGHT.	DIFFERENCE.	LEFT.	RIGHT.	DIFFERENCE.	LEFT.	RIGHT.	DIFFERENCE.
Frontal.....	36.4.....	36.6.....	plus 0.2.....	34.....	34.....	0.....	32.8.....	32.2.....	minus 0.6.....
Acromion.....	".....	".....	".....	31.....	29.8.....	minus 1.2.....	33.9.....	34.9.....	plus 1.....
Breast.....	35.7.....	36.6.....	plus 0.9.....	33.1.....	33.4.....	plus 0.3.....	35.....	35.6.....	plus 0.6.....
Hip.....	36.8.....	38.4.....	plus 1.6.....	35.6.....	34.1.....	minus 1.5.....	34.9.....	34.....	minus 0.9.....
Thigh.....	35.1.....	35.....	minus 0.1.....	".....	".....	".....	".....	".....	".....
Foot.....	34.9.....	34.9.....	0.....	31.2.....	30.6.....	minus 0.6.....	34.2.....	33.....	minus 1.2.....
Hand.....	".....	".....	".....	31.8.....	33.9.....	plus 2.1.....	.....	.....	.....
 IDIOT.									
REGION.	LEFT.	RIGHT.	DIFFERENCE.	LEFT.	RIGHT.	DIFFERENCE.	LEFT.	RIGHT.	DIFFERENCE.
Frontal.....	36.1.....	36.....	minus 0.1.....	37.7.....	37.4.....	minus 0.3.....	.....	.....	.....
Acromion.....	34.4.....	34.6.....	plus 0.2.....	36.6.....	36.2.....	minus 0.4.....	.....	.....	.....
Breast.....	35.2.....	35.3.....	plus 0.1.....	37.3.....	37.9.....	plus 0.6.....	.....	.....	.....
Hip.....	37.2.....	37.2.....	0.....	35.9.....	36.3.....	plus 0.4.....	.....	.....	.....
Thigh.....	".....	".....	".....	35.1.....	35.4.....	plus 0.3.....	.....	.....	.....

SHOWING RIGHT HYPOTHERMIA IN RELATION TO THE SYMMETRICAL LEFT SIDE IN TWO NORMAL SUBJECTS AND THE AVERAGE DIFFERENTIAL TEM- PERATURE IN THE GENERAL PARALYTIC AND IN THE NORMAL SUBJECT.

	NORMAL SUBJECT.	NORMAL SUBJECT.	DIFFERENTIAL GEN. PARAL.	TEMP. IN NORMAL SUB.
Frontal.....	minus 0.1.....	plus 0.2.....	0.6.....	0.1,7.....
Deltoid.....	plus 0.2....	minus 0.3.....	0.6.....	0.2,7.....
Breast	plus 0.3.....	minus 0.2.....	0.7.....	0.3.
Hip.....	plus 0.3.....	0.....	0.8.....	0.1,7.....
Thigh	".....	plus 0.1.....	0.6.....	0.2
Hand.....	plus 0.1.....	plus 0.2.....	1.5.....	0.1.5.....
Foot.....	0.....	0.....	0.3.....	0

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A CASE OF PATHOLOGICAL SLEEP IN A HYSTERICAL SUBJECT.

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In contrast to the disturbance of sleep known as insomnia, there exists a form expressed by excessive sleepiness. This disturbance may be encountered during the course of various nervous and psychic diseases as well as an accompaniment of disturbed metabolism. This disturbance may manifest itself in various outward forms; these forms may vary in their genesis as well as in their internal mechanism. In most instances, pathological sleep is only part of a complexus of disturbances of which epilepsy, hysteria and other diseases are the representative pathological forms. Narcolepsy, which was considered in the past by some authors as an individual disease, is now looked on as a symptom of some disease. I shall not consider here pathological sleepiness as an accompaniment of various diseases; I shall not touch, either, on the consideration of the various forms of this condition as they can be observed during the course of the same disease, as in hysteria. I only wish to attract the reader's attention to the analysis of one of the manifestations of pathological sleepiness as it was manifested during the course of a psychosis. The analysis is based on the facts observed in a case cited below.

The patient is an unmarried woman, twenty-three years of age. Her mother is of a nervous disposition, has delirium of doubt and has physical stigmata of degeneracy. Three paternal cousins suffered from mental disturbances, one of whom has recovered. The patient herself has always been of a nervous disposition and inclined to have hysterical spells. As a child, she made excellent progress in her studies and was considerably interested in her work. In 1900, she travelled extensively, attended the Paris exposition, and soon began to show signs of fatigue from travel; she became very nervous, impressionable and generally broken down in health. About that period she also sustained a severe fright, as she and her friends had a narrow escape from shipwreck. Her health was considerably undermined during that year and the patient contributed still further towards reducing her health by having undertaken a trying task of teaching, although she was in

monetary ease. In July, 1900, it was seen from her letters to her brother that some change was taking place in her mental condition, as she wrote him a plaintive letter about her health and did not sign the letter. Later on she sustained some further shocks: she was frightened by being thrown under a horse and soon after another fright shocked her when seeing her favorite pupil, a little girl, in a runaway while riding horseback. She now became subject to frequent hysterical spells and was obliged to return home. Her moods were quite unstable at this period; she was now exalted, now depressed and began to fear that she was being shunned by those near her. Her first sleeping spells now made appearance: she became drowsy in the afternoon, lapsed into sleep and even had convulsions during this peculiar sleep. At times, she had a hysterical attack first and the sleeping spell followed later on. At times also, she complained of being hypnotized, followed by imaginary persons and odors (*eau de cologne*, etc.). At night, she often suffered from severe fright; there were also various ideas of persecutions of an erotic nature. Physically, the patient had failed gradually; during the Summer of 1901, she looked considerably reduced in flesh and the menses had stopped in May of that year. I examined her in September and she gave me the following account: She had noticed a marked change in her psychical condition beginning with May, 1901; she was very excitable while giving the account of herself; she said that she had lost her will power and that she was being hypnotized; she saw flashes of light in the adjoining room. Whatever she told me was stamped with a childishness that did not harmonize with her age. Physically, there were exaggerated knee reflexes and cold extremities. She also said that she often had a sensation of a ball choking her in the throat. In September, the patient was quite irritable, suspicious and said that people were plotting against her; at times she was quiet, however. During the month of September she also had an attack of hysterical syncope. At times she scolded those about her and showed some erotic excitation. In October, her condition continued to be about the same, as she was now irritable and excitable, now disinterested in her surroundings; her mental condition was quite changed at present and was expressed by oddness in her conduct as well as in acts: without any anger or purpose, for instance, she knotted sewing thread around a sewing machine; at another time, she suddenly ran up to a looking glass and broke it; when explaining the reason of this deed she said that the broken glass would make people think of an approaching misfortune. She showed unusual conduct in many other ways: she began preparations for the publication

of a periodical for children and spent a good deal of time in making clippings of news and illustrations; she then started her autobiography, and illustrated it by odd symbols and figures; she moralized on philosophical questions of life, on man and woman and on other questions. She forsook all occupation for these generalities.

The sleepiness which I am considering here now showed itself to the fullest extent. Her appetite was considerably increased above the normal and she showed unusual sleepiness. The development of the disturbance of sleep was about as follows: During the Summer of 1901, when the psychic disturbances were quite advanced, the first signs of disturbed sleep showed themselves. At first, there was simple insomnia during certain nights and the patient often overslept herself until late in the morning. Later on the sleepiness became more and more pronounced; this was particularly marked after she had had a hysterical attack. Towards the end of October, the patient experienced an absolute need to sleep abnormally long hours; she said that sleep was to her a most delightful rest. She finally found it necessary to remain in bed during the entire day. She took her meals regularly, but went to bed immediately after she had finished eating; she exchanged greetings with the members of her family while she was in bed and fell into a profound sleep during the conversation. She was brought to me for examination at about that period, and her mother states that on her return home after the consultation the patient immediately went to bed and fell into a profound sleep; the following few days were then spent in sleep, without any nourishment being taken. The function of the bowels had been normal up to that time, but there was no bowel movement during these few days. Those who nursed her during this time state that she left her bed now and then, her eyes being half open, and went to the water closet to urinate, or helped herself to a glass of water which was at hand, near her bed. She got out of bed in this manner preferably at four o'clock in the morning; she seldom got up in the day time.

I saw the patient November 18,—four days after she had been in this pathological sleep. She was lying on her back and her eyes were closed, the color of her face being quite good. I happened to shake her bed unintentionally, and her face colored slightly, while the facial muscles showed signs of life; the expression she had then might be called that of a smile; her eyes remained closed all this time. When I called her by her name she remained immovable and did not reply. The family physician then called to her insistently and she opened her eyes; she did not

look at any one; she simply fixed them on a certain point on the wall and looked without flinching; she then began to cry hysterically and had some hysterical contractions of the body. When her mother gave her some water in a glass to sip, she swallowed some of it and then pushed the glass away with her hand; she did all this with her eyes closed. She then remained on her back, breathing regularly. An examination was made for hysterical stigmata in the region of the pelvis and elsewhere, but she stood the pressure without showing that she was hypersensitive in any part of her body. This prolonged sleep lasted until November 21; after this date, it was noticed that the patient got out of her bed more frequently and drank more water; she was seen often to drink as many as four glasses of water during the twenty-four hours. She woke up on November 21, but did not seem to know what had happened to her; she simply remarked that she was very sleepy. She said that she knew of the visit of the two physicians and gave their names; she could not converse with them, she said, because it was difficult for her to open her eyes and that she was very sleepy.

The bowels were now emptied by a rectal injection, and the patient ate quite well; she was still sleepy through the day, but there were lucid intervals when she conversed with those near her; she complained of feeling weak.

A second long sleeping spell took place December 1: she slept thirty-eight hours at a stretch, without even having a drink of water. According to the mother's account, the patient remained on her back most of the time and the color of her face was now pale, now pink; she woke up at certain intervals and went to the water closet, but fell asleep again immediately on getting back to bed; every time after her getting up, the sleep lasted twenty-four hours. December fourth, the patient remained with her eyes open during a period of three hours; there seemed to be no reaction of the pupils and she looked fixedly at one point; she then again fell asleep. During the night of December 5, she again remained with her eyes open, as before, during a period of four hours, motionless, and fell asleep, as she had on the previous occasion. She woke up on the morning of December 6, exchanged some words with her relatives, refused to eat and again fell asleep; she slept until December 6, when she woke up definitely, had something to eat and remained awake through the day. She had a hysterical spell during the night of December 7, fell asleep after it and slept until December 9th. During these three days she did not eat anything; she only got out of bed to attend to her wants and to have a drink of water, taking one or two glasses of water

in the twenty-four hours. Between the 9th and 11th of December, the sleepiness was not marked; the patient slept at night, but she was in a normal condition during the day.

In this case the question is undoubtedly that of pathological sleep, which should be recognized as such from the quantitative as well as from the qualitative point of view. Pathological sleep is met with in hysterical subjects who are also afflicted with a mental disease; therefore, we should not consider the pathological sleep in question as being of hysterical nature only. The pathological sleep in this case was only one of a number of symptoms apt to characterize a psychosis which developed in a hysterical person.

It is well known that pathological sleep may be of various origins. I think that pathological sleep may be divided into two principal groups: I,—pathological sleep due to an organic cerebral lesion (cerebral swelling, arterio-sclerosis, senile involution, general paralysis, inflamed meninges, etc.) and II,—pathological sleep without any anatomical basis; into this class we may enter the following varieties of sleep: hysterical, epileptic, that due to intoxication, to imperfect metabolism, etc. To this group also belong the varieties of pathological sleep often met with in functional psychic disturbances. There is a form of this variety of pathological sleep which might be called pseudo—or apparent sleep. During such sleep the patient keeps his eyes closed, remains immovable, does not answer questions addressed to him, takes no interest in his surroundings, does not take any food, except what is artificially introduced into his stomach, does not micturate voluntarily, remaining like an inert mass, irresponsible even when carried from one place to another; it is possible, however, to differentiate this condition from that of real pathological sleep by the mode of breathing and the reflex movements of the eye-lids. Ballet (1) has termed such conditions “simulated sleep of the insane.”

There exists a great difference, however, between the simulated sleep described by Ballet and that observed in our case. In cases of simulation, the patient remains immovable, does not leave his bed, does not eat at all, and voluntarily, so to speak, does not react to his surroundings; such patients give the impression of acting under the dictates of delirious ideas. In our case, on the contrary, there is a natural, so-called, tendency to sleep, there being an irresistible desire to sleep: the patient experienced a great difficulty in keeping her eyes open, she got up now and then to take a drink of water, to micturate, and at times she could be waked up. On the other hand, while it is difficult to affirm in

this variety of simulated sleep whether the patient is asleep or not, the genuineness of the sleep could not be doubted in our case. It was difficult to wake her up, but once awake she acted normally, spoke normally, ate heartily and was fully aware that she had been asleep.

From the analysis of this case I conclude that the pathological sleep here considered has two morbid elements. Firstly, the patient unconsciously tried to isolate herself from outside impressions; this she did under the influence of her mystic delusional ideas. The patient remarked herself that she had fantastic ideas. The latter could easily be compared to those induced by toxic doses of hashish. Secondly, there was a distinct hysterical phase of the disease, as the patient showed distinct hysterical tendencies during the course of the disturbance as well as before its onset.

The above mentioned two elements of this pathological sleep are so intimately interwoven that it is difficult to point out exactly where the one ends or the other begins; I am enabled to point out, however, that this sleep was most pronounced while the patient was distinctly afflicted with a psychic disturbance,—while she was suffering from delusional ideas; there seemed to be no exclusive dependence between the sleep and her hysterical spells and convulsions.

My case resembles a good deal that described by Szczypiorski (2). In his case the sleeping spells were very much more prolonged; the author explains the phenomenon by saying that during the course of delusional insanity the patient often seeks to isolate himself from the external world in order to better give his attention to his delusional thoughts or else to inflict on himself voluntary punishment. Discussing the possibility of a double nature of the sleep in his patient, he insists that there was a large element of spontaneity.

The reader can find a detailed consideration of pathological sleep, particularly of hysterical nature, in Gilles de la Tourette's works (3), where an extensive list of references can be found; Rich. Benjamin's contribution to this question is also a valuable one (4).

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ON ACUTE PARANOIA.*

By P. GANNOUCHKINE.

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I. The progress of clinical psychiatry has been quite marked within the last few years; the science of psychiatry properly speaking has not made much progress, however; this is particularly true of some of its branches, which remain as obscure to the understanding as they were many years ago. Thus, what Salgo said fifteen years ago, in his compendium of psychiatry, in 1889, regarding the limitations of psychiatric precision, remains true even to-day; he claimed that the teaching of mental diseases was limited to the exposition of certain symptoms, more or less complex; these limitations were applicable, according to this author, to general paralysis, mania, amentia of Meynert and paranoïa as well as to other forms of insanity. This statement is quite as valid to-day as it was many years ago. Thus, Meschede states in our own day that the terms melancholia, mania, dementia and paranoïa should be considered as definitions of certain conditions, but not as nosological units.

We shall, therefore, consider acute paranoïa as a symptom-complex. It is generally admitted that acute paranoïa may be an accompaniment of chronic alcoholism, cocaïnism and of other intoxications; in fact, such cases are not at all rare in occurrence. Recently (1) it has even been stated that there existed an intimate relationship between paranoïa and mental conditions due to intoxications, and Pick (2) finds that there is a marked analogy between these conditions.

As regards acute paranoïa itself,—some authors do not even give it any clinical consideration: Krafft-Ebing entirely omits any mention of the disease in his text-book on psychiatry and Kraepelin makes no mention of it in his work, except to state that it is impossible to consider this disease; Korsakoff, on the contrary, devotes as much space to the consideration of this disease as he

*Simultaneous publication in *Journal S. S. Korsakova*.

does to that of other mental affections. It is thus evident that the question of the consideration of the symptom-complex acute paranoïa is not a simple one. However, when analyzed as a symptom-complex acute, paranoïa suggests the necessity of considering two important points: 1, the differentiation of the psychoses said to be due to intellectual disturbances (Jolly, Ziehen and Cramer) from those due to an impairment of the emotional sphere; 2, the consideration of the relation between the forms of this group of acute psychoses to the well defined symptom-complex known under the term of chronic paranoïa (*primære ver-ruektheit*).

In its purest form this variety of acute psychosis should present the same characteristics as does chronic paranoïa, with the exception of the chronicity and of the incurability proper to the latter.

To touch on the finer differentiation, the following is generally accepted: mania and melancholia are generally excluded from the group of emotional psychoses; from the group of the so-called psychoses of the intellect are excluded the following three forms: 1, acute, curable mental enfeeblement, 2, acute mental confusion or Meynert's amentia and 3, acute paranoïa. In acute mental enfeeblement the first noticeable sign is a lowered mental level, while in amentia the first sign is an impairment in the mechanism of association of ideas; the confusion of ideas observed in this disease is the result of this impairment. In acute paranoïa the most noticeable sign is the delirious relation of the patient to his surroundings. According to Schuele (3) acute paranoïa is characterized by the fixed nature of the hallucinations and of the delirium; the condition of consciousness does not play any important part here. At the risk of incurring the disapproval of my colleagues for being a partisan to terminology, I wish to endorse the three sub-divisions of acute psychoses: anoïa, proposed by Jolly (4), dysnoïa, proposed by S. S. Korsakoff (5) and finally, paranoïa. These three varieties may be either acute or chronic in form.

Before touching on the question of acute paranoïa properly speaking, I wish to make some remarks on the relation of acute to periodic paranoïa. I think that these two forms of psychoses are not only intimately related to each other, but also that if we can prove to our satisfaction the existence of one of these forms the existence of the other becomes a necessary clinical corollary. As is well known, all acute psychoses are apt to terminate in recurrent forms. It is difficult, however, to draw a distinct line of demarkation between a periodic and an ordinary recurrence. This statement is self evident when we consider the recurrence of psy-

choses after child-births or after menstrual periods. We are generally accustomed to characterizing the onset of periodic diseases according to the abruptness of onset, the apparent absence of cause, a set time of the onset, a more or less definite duration of the course of the disease and, finally, a complete recovery from every attack. All these signs cannot be said to have an absolute clinical value for the purpose of determining the periodicity or non-periodicity of a disease, as even the form of the affection may differ at different times; Kausch (6), for instance, reports a case in which the first attacks of the disease resembled those of melancholia, while the later ones were typical of paranoïa; Mendel (7) reports a case that presented, alternately, characteristics of melancholia, mania and paranoïa.

II. Before proceeding with the consideration of acute paranoïa, I wish to make some remarks on the literature on this symptom-complex. The essential point for consideration in this literature is the relation of acute paranoïa to acute mental confusion, that is to say, to amentia of Meynert. Some authors make no distinction between acute paranoïa and acute mental confusion, either from the standpoint of classification or from that of clinical manifestation; a second group of authors, on the contrary, make a sharp distinction between these two mental affections. The first group of authors may be divided into two sub-groups:

1, those who do not distinguish between acute paranoïa and acute mental confusion and class both with primary mental confusion; in other words, these diseases are classed as sub-forms of paranoïa; 2, those who do not admit the existence of any identity between the various forms of the acute psychoses in question and chronic paranoïa; they class these acute psychoses under various terms, leaving the term acute paranoïa for the variety of affection which becomes chronic and incurable.

Westphal (8) belongs to the first group of authors; he was the first one to point out the acute psychoses which resembled chronic paranoïa and to group them as a special sub-variety of paranoïa (*Verruecktheit*). Espent (9), one of Westphal's pupils, used this classification; Mercklin (10) and Schaefer (11) belong to the same group of authors. The second group of authors comprises Ziehen (12), Cramer (13), and Gallus (14).

The second set of authors,—those who draw a distinct line of demarkation between the acute psychoses in question and chronic paranoïa, are headed by Herz (15); Fritsch (16) and Meynert pointed out especially the fact that in all these acute psychoses the characteristic traits were a condition of confused consciousness

and a difficulty in orientation; these traits seemed to them so characteristic that they applied the term confusion (*verwirrheit*) to the whole group of these acute diseases; they did not include in this group chronic paranoïa; no distinction was made, however, between acute mental confusion and acute paranoïa. Meynert had a powerful influence on his contemporaries in thus considering these diseases, and among his followers might be counted Conrad (18), Mayser (19), Sally (20), Scholz (21), and Krafft-Ebing. The latter considered the acute psychoses in question under the heading of *hallucinatorische Wahnsinn*; he classed chronic cases with paranoïa. Kraepelin belongs to the same group of authors if his opinion is judged from his text book on Psychiatry, in the fifth and sixth editions; he differed from these authors in his text book in other editions—the third and fourth.

There exists also an intermediary group of authors who draw a line of demarkation between acute mental confusion and acute paranoïa, not from a qualitative but from a quantitative point of view; the pathological process is said by them to be the same in both instances—in the beginning of the affection. Hoppe (22) and Keraval (23) are the leading authors of these opinions. A sub-group of authors of this class draw a distinct line of demarkation between acute mental confusion and acute paranoïa, insisting that there must be a special individual predisposition for the development of paranoïa. Séglas (24), Friedmann (25) and Cattani (26) belong to this sub-group of authors; they consider mental degeneracy as a predecessor of acute paranoïa. Jastrovitch (27) considers that mental enfeeblement and mental debility are forerunners of acute paranoïa.

Another sub-group of authors consider acute paranoïa as a disease with an individual course and termination, but its form is looked on as being intermediary, mixed, the clinical aspect of which is also proper to some disease of more defined form. Kraepelin is one of these authors and considers the disease in this wise in his text book, in the third and fourth editions. He considers acute paranoïa as an intermediary disease between chronic paranoïa and the emotional psychoses (*mania* and *melancholia*); he therefore considers that the affective life of the individual with acute paranoïa must be impaired. Kirschoff (28) seems to be of similar opinion; according to him acute paranoïa may appear in two forms,—with affective depression or else exhilaration. To this group of authors also belongs Serbski (29). S. S. Korsakoff (30) may be said to belong to the same group; although he finds three distinct types of acute paranoïa, he considers the whole type of the disease as a transitory form. This author looks on

acute paranoïa as on a transitory form between chronic paranoïa and amentia of Meynert; Kraepelin, Serbski and Kirschoff, however, look on acute paranoïa as on a transitory form between chronic paranoïa and the emotional psychoses (mania and melancholia).

A fourth group of authors entirely individualize acute paranoïa and differentiate it from acute mental confusion. To this group belong Kretz (31), Wille (32), Mendel (33), Werner (34), Schoenthal (35), Neisser (36), Chaslin (37), Smelov (38), Kaeppen (39) and Schuele (40).

Alongside with the forms of paranoïa considered above there is yet another form—periodic paranoïa. Dagonet (41) was one of the first authors who considered this disease; Mendel (42), Kausch (43), Ziehen (44), and Meschede (45) have also described it.

I make mention of the description of periodic paranoïa because I think that the investigation of this disease coincides with that of acute paranoïa and in the description of the former there is much to be found that proves the existence of the latter. Séglas (46) remarks that Lasègue gave birth to the term paranoïa in France and that the question of this disease was worked out in Germany.

III. The abundance of literature on the question of acute paranoïa is a good proof of the existence of the disease; the proof is much strengthened by the cited examples of this form of affection. As I am treating of this question, I cite here two cases of acute paranoïa that I studied at the Moscow Psychiatric Clinic.*

Case I.—The patient is thirty-six years old and was a railroad employé. His father was a country preacher and suffered from some scalp disease; his mother also suffered from some scalp affection and, besides, she was of a very nervous temperament; a maternal uncle was an alcoholist and a maternal grand-uncle was also an alcoholist; two maternal cousins were afflicted with mental diseases and the patient's sister was of a highly nervous temperament.

The patient was born in the country and his psychic development was quite normal during his childhood; he obtained his education in a seminary and then became a city school teacher. In 1882, he had a chancre and six months later he had a typical syphilitic eruption; he also had a syphilitic sore throat and alopecia. In 1887, he spent four months in prison for some political

* I am indebted to Dr. Serbski for the privilege of studying the clinical material here cited.

offense. While he was serving his time in prison he began to suffer from insomnia and delusional ideas of persecution alongside with hallucinations of hearing. He imagined that his friends had caused his arrest, although at times he recognized the absurdity of this idea. He spent three months in the infirmary of the prison and was then sent away to Onega for three years, where he seemed to have been in good condition. On obtaining his liberty he took up again his work as a railroad employé. In 1893, he became quite suspicious of his friends, imagining that he was being persecuted, that his persecutors plotted against him even in his presence and expressed themselves by means of signs; he even imagined that these signs were used everywhere: when he saw some word in a book underscored he thought that his persecutors had underscored the word. He then began to examine every bit of printed paper that came to hand, such as wrapping paper in which his groceries were delivered; every line found on the paper had some particular meaning to him; besides, he began to give delusional interpretations to everything about him, either heard or seen. Thus, on hearing pronounced a name which sounded like Horn he concluded that it was hinted that the sheaves were arranged crooked—like horns; he picked up a daily paper which was lying on the table and noticed that a crumb of bread was sticking to one of the letters; he therefore concluded that the crumb had some particularly bad meaning for him. He then imagined that evil was being done him by means of electricity and hypnotism and suspected that his co-workers were responsible for it. He suffered also from disturbances of the general sensibility and of the special senses: he felt electric currents in his body, he smelt chloroform that was being used to harm him, etc.

He was admitted to the Moscow Clinic, September 25, 1893, and the following was then his condition: He was in fairly good physical condition and seemed to understand his surroundings. He kept himself aloof and spent most of his time in reading, although he did not grasp clearly all that he read. His mental condition was about the same as above described: he heard whispers of his plotters, he gave delusional interpretations to everything he saw or heard and the delusions were of a somewhat erotic nature, now and then; he imagined that he was in a house of ill fame. These delusional ideas with the numerous delusional interpretations lasted some two months after his admission to the clinic; the patient then began to improve rapidly and was completely free from all these signs within the following two months; he was then discharged as a cured subject.

Case II.—The patient is a young man, twenty-three years of

age, a university student. His father is of a nervous disposition and his mother is a hysterical subject. There is no record of hysteria or of nervousness among the other members of the parent's family.

The patient is one of twins; his twin sister is dead. During childhood he had twice pneumonia and once typhoid fever. He has always been suspicious, depressed and isolated himself from those about him; his peculiar character caused him many unpleasant encounters with his friends and professors. In addition to this, his home life was unsatisfactory. He began to study medicine in 1891, but he did not work very earnestly. At the end of the academic year he began to doubt the wisdom of his choice of study and finally decided to take up the study of law. While calling on one of his fellow students he suddenly began to cry, saying that he was considered by his colleagues as a fool and that he was shunned by them; this condition of emotion continued about twenty-four hours; he then left for the country where he improved in health and seemed to study quite seriously; this was during the month of May. In September, he returned to the city and soon after began to suffer from delusions of persecution; he suspected his own relatives of plotting against him, of making arrangements to send him out of the house, etc. He now suffered from insomnia and loss of appetite; he was very emotional, cried easily and his affective life was upset in general. Towards the middle of September, he found himself among friends, at an evening, and his friends noticed that his ideas were confused, his memory failed him and he could not name persons properly; he then went up to one of the visitors, who was a military officer, and explained that some one wished to arrest him but that he (the patient) was not guilty of any misdemeanor and could not understand why he should be arrested; he further explained that all that was said about him was not true. He complained that the members of his own family were his persecutors, that he learned this that evening and that he wished that everything be explained on the spot. He said that his relatives put a forbidden book in his room in order to cause his arrest. He was taken home and cared for; two days later he had an attack of syncope. He was admitted to the Moscow Clinic, September 19.

His internal organs were in good condition. His teeth and ears bore stigmata of degeneracy; his consciousness was perfectly intact and he answered questions clearly, entering a good many details to substantiate his words, although they had no bearing on the question. He showed a great tendency to argue and demonstrated thus that he was being persecuted. He said

that he heard hints, that he saw gestures and that he heard whispers,—all these were intended to further a plot against him. He cried very easily when he spoke of these persecutions; he recognized that he was in a very emotional condition. September 25, he remained in about the same condition, imagined that he had really been arrested and still complained of his imaginary persecutors; one of his relatives, however, had really done him an injustice and the patient classed him with the imaginary enemies. Later on he suspected everybody in the clinic of plotting against him, of attempting to poison him through his food; this delusional condition continued until the following January, when he recognized that he was ill; his conduct began to improve noticeably in March and he was discharged soon after as a cured subject. News received about him some time after his discharge informed us that he was doing well.

Both these cases are examples of the purest forms of acute paranoïa. I shall not stop to analyze them, but wish to remark that they both present a marked resemblance to chronic paranoïa; nevertheless both ended in convalescence in a comparatively short space of time. Just as acute, curable mental enfeeblement may simulate the incurable form of this disease, so may acute paranoïa simulate the chronic form.

It is not within the province of this paper to analyze the course and the various forms of acute paranoïa. The aim here was that of establishing once more the possibility of the existence of this form of paranoïa.

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CRITICISM VERSUS CANT.

At the recent Annual Convention of the American Medico-Psychological Association, held at Montreal, a paper dealing with the problems confronting the American psychiatrists was presented by Dr. Robinovitch, which paper was published in full in the July issue of this Journal. The author therein deplored the shortcomings of the present system of administration in some of our hospitals for the insane, a system that compels some of the superintendents of our insane asylums to devote a great part of their time, if not all of it, to purely clerical work, and which inevitably forces the young resident assistants into the same undesirable rut. The gist of the paper was to the effect that this system is antiquated and barbarous, and should be done away with, and that the superintendents and their assistants should be enabled to devote their time to the study of mental diseases, rather than to the study of bookkeeping. Cases were cited in corroboration of these arguments. The paper also urged the introduction of an intelligent and modern system of classification of mental diseases.

As was to be expected, some of the less progressive representatives present at this meeting felt offended and mortified.

No one likes to be found fault with, and criticism has never yet, in the history of the world, been received with favor by the criticised. Nevertheless, no one has ever assumed to hold that it was wrong to criticise existing conditions because to do so would hurt someone's feelings. In the course of the world's evolution, to say nothing of the evolution of science, the feelings of many people have been hurt, and advocates of existing systems have received many metaphorical black eyes in opposing the forward march of scientific enlightenment.

It seems rather curious, therefore, to find, in a recent issue of the *Philadelphia Medical Journal*, the following editorial comment on the paper above mentioned:—

Psychiatry in America.—It is much to be wished that some of the younger generation of psychiatrists in this country would confine themselves in their writings to telling how much they themselves know instead of describing how little other and older persons know. In a paper read at the recent meeting of the American Medico-Psychological Association at Montreal, Dr. Louise G. Robinovitch read a paper in which she drew a comparison between the work done in European asylums and that done in American asylums. The comparison was altogether uncomplimentary to the American institutions and reads like a travesty. We are not surprised to learn from a foot-note by Dr. Robinovitch herself that the reading of her paper was "received with marked disfavor." It could be roundly criticised for poor taste, if for nothing else. We are quite convinced that American hospitals for the insane occupy as high a plane of efficiency as some of their critics. Some of these hospitals are doing good scientific work, and all of them are at least discharging the duty for which they were primarily instituted, i. e., the care of the insane. Questions of classification, on which Dr. Robinovitch lays such exaggerated stress, are justly not deemed of as much importance among us as the cure of patients. Her paper was merely academic.

We can only deplore, for their own sake, the strabismic vision of those students in psychiatry who can see nothing but what is admirable in Europe and nothing but what is reprehensible in America. The only injury done is to their own influence.

We thoroughly appreciate the courtesy and veneration due to "older persons," but respectfully beg to argue that if all the workers in the various lines of science had continued, from time immemorial, to bow to the edicts and pronunciamentoes of "older persons," we might still be travelling across the continent in comfortable, if slightly cumbrous, stage-coaches, and such a thing as wireless telegraphy might still remain an asset to be found only in the storehouse of the highly imaginative writer of romance.

It is "nice" to be patriotic, and to meet every criticism with the cry that all things "ours" are better than all things that are not

"ours." But it would seem to us that science knows neither nations nor continents. If one particular section of the earth's surface develops a system of schools that induces earnest students to work and learn something, and if another system of environment, or ignorant inanition, or pompous self-satisfaction, produces a system that can be likened only to the Chinese Wall in its exclusion of all but officially designated "experts," hired, after the manner of clerks, to "do researches" of some indefinite nature or other, it is not in the province of the scientist to plead "patriotism" as an excuse for monumental stupidity and positively harmful as well as dangerous ignorance.

The American spirit of perseverance and original endeavor will, if untrammeled by official shackles, produce students who will easily take their station in the world of psychiatry. But psychiatry will not flourish, neither will psychiatric research produce results in some of our hospitals for the insane, until the powers that be recognize these basic principles,—that progress is nurtured and furthered by dissatisfaction with present conditions, and that men cannot be officially created students; the student makes himself, and all he asks is opportunity, which should not be denied to him. That opportunity is not afforded to the student in some of our hospitals for the insane is not to be denied; that this "shutting out of the outsider" is stupid and harmful needs no demonstration. That the present sterility in the pursuit of original researches in some parts of our country is due to anything other than lack of opportunity is beyond question. Give the American student opportunity and you can trust him for results.

The *Philadelphia Medical Journal*, in the editorial above quoted, refers to the question of classification. One can hardly take that reference seriously. A sheer sense of curiosity compels us to respectfully enquire what the miraculous manner is in which the insane patients are "cured" by those having charge of them, without regard to the lack of knowledge of the particular disease with which the patient is afflicted. It seems to be the generally prevalent belief that it is well for a physician to know with what variety of disease his patient is afflicted before he undertakes to prescribe treatment. If our contemporary has some novel method of effecting the "cure of patients," when they are insane, without regard to the particular form of disease to which they are subject, it would render an invaluable service to humanity if it would reveal its secret.

To speak seriously about this matter, however, we must admit that the essence of our contemporary's editorial may be attributed to no fact other than the deplorable general lack of understand-

ing of what insanity is and how it should be diagnosed,—the very condition of which Dr. Robinovitch so bitterly complained in the paper read by her. We do not deny that there have been recent improvements in the housing of the insane, neither do we for a moment deny that there are many institutions in the United States in which little is left to be desired in every way;—the fact remains, however, that many of our large institutions are sadly mismanaged and neglected and isolated from every progressive thought or movement. These institutions should be reached and reformed, regardless of the age or social standing of those who are mismanaging them, and if a description of their management sounds like a travesty, it is because the management is indeed a travesty—a travesty on intelligence and—in some cases—on common decency. Personalities have no place in the discussion of a work so important—the task is too serious and important,—and even sacred.

Owing to the unavoidable delay in the return from abroad of the Editor of this Journal, the October and November issues have been consolidated into one number and the same course will be pursued with the December-January issues.

The death of Dr. Daniel E. Hughes, of Philadelphia, removes from active work one who has ever been a disciple of earnest, self-sacrificing, constant effort. He was a scientific worker of note, a good physician and a friend to cherish. Dr. Hughes was a man hard to match among millions, and words cannot be found to fitly describe our sorrow at the news of his tragic ending.

TWELFTH CONGRESS OF FRENCH AND FRENCH-SPEAKING ALIENISTS AND NEUROLOGISTS.*

This Congress was held August, 1902, at Grenoble, France, under the presidency of Dr. Regis, of Bordeaux. The following are abstracts of a few of the interesting papers read there:

PROFESSOR JOFFROY AND E. MERCIER.—On the Utility of Lumbar Puncture in the Diagnosis of General Paralysis: In the normal cerebro-spinal fluid leucocytes are either absent or else they vary between 0 and 2 per cubic millimeter; in general paralysis, this number is very much higher. Lumbar puncture has, therefore, become a valuable method for the

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purpose of making a definite diagnosis in doubtful cases of general paralysis.

E. NOGUES.—**Tics in General:** An instructive review of the literature on tics is made and the author's own views on the subject are added. Tics should be differentiated from spasms. A spasm is a motor reaction resulting from a pathological irritation in the spinal or the bulbo-spinal tract. In movements that come under the heading of tics the cerebral cortex must participate, to some extent, in the formation of the movement. The term "tic douloureux" is an erroneous one and has caused a good deal of confusion of ideas in the terminology as applied to tics. A tic is not the result of a peripheral nerve affection; it is a disease connected with some psychic peculiarities. The term "involuntary tic" is incorrect from a clinical point of view because all authors agree that tics can be stopped by the exercise of the will. Besides, every tic is preceded in the course of its evolution by a repetition of movements that are voluntary in nature, the habit of having a tic becoming established subsequently. Certain incoördinate automatic movements are often called tics, whereas in reality they are not tics: they are stopped the moment the attention is sufficiently free to take notice of the ordinary surroundings. In case of a genuine tic the pathological act cannot be interrupted without a marked degree of painful effort of the will being exercised for that purpose. Some authors say that tics are conscious acts while others consider the act of the tic unconscious. Both opinions are quite correct: the act is accomplished unconsciously, yet the subject is perfectly conscious of his bad habit. A tic is a functional disturbance, of psychic origin, which Meige calls a parasite function. One finds in the performance of the tic all the characteristics of a functional disturbance: repetition of the act, premonitory anxiety and, finally, a sense of satisfaction after the act has been accomplished. From a psychic standpoint there exists a remarkable resemblance between tics and obsessions so far as the irresistible wish to accomplish the act is concerned. Physiologically, there are two kinds of tics: clonic and tonic. The clonic variety is the most familiar to the clinician; in the case of the tonic tics the diagnosis between these and simple spasms becomes rather difficult. Prominent characteristics of subjects afflicted with tics are: inability to appreciate the position of their limbs and lack of precision of direction and amplitude in the execution of voluntary motor acts.

The Mental State of Those Subject to Tics.—The will power of those subject to tics is not strong; in fact these subjects

belong to the large group of the degenerate; the psychic state of those subject to tics may easily be compared to that of the period of childhood; their impatience, their instability of motive, purpose and accomplishment quite justifies the comparison; the unevenness of psychic development also allows of this comparison. This infantile type of mental development should not be taken for that observed in cretinism; the best way to properly convey the picture of the mental state in the subject here considered is to say that he can be compared to the superior degenerate of Magnan or to the simple degenerate of Ballet. This fact is so true that it is not a rare occurrence to find these subjects afflicted with obsessions and with impulses. The presence of psychic stigmata in these subjects may give rise to the tics; the latter, on the other hand, may give rise to obsessions and impulses. In analogy to the division of the morbid obsessions and impulses, given by Régis and Pitres, tics can be classified as follows:

1. *Psychic tics or obsessional tics*: there exists an interval between the time of stimulation and the accomplishment of the act; the struggle for inhibition of the act may end successfully.

2. *Psycho-motor tics*: the muscular movements follow invariably even though not always immediately after the stimulation; there is an accompanying intermediary emotional or ideo-emotional state, but without any serious inhibitory attempt.

3. *Purely motor tics*: The movement always follows directly after the stimulation, without there being any intermediary inhibitory period.

A tic is easily comparable to an impulsive obsession.

GASTON LALANNE.—On the Anxious States in Mental Diseases: Anxiety exists in the morbid subject in the same form as it does in the normal one.

Pathogenesis of Anxiety: James and Lange ascribe too exclusive a rôle to the vaso-motor disturbances in the genesis of anxiety; the great sympathetic should be considered in connection with the formation of this condition. Physiologically, the state of anxiety is intimately connected with the condition of the great sympathetic nerve; other emotional states are similarly connected with the condition of this nerve. Auto-infection plays a considerable part in disturbing the normal function of this nerve and thus affects the normal emotional state of the subject. The great sympathetic is the regulator not only of the internal but also of the external disturbers of the harmonious conditions of the organism. A markedly noxious condition of the blood is very apt to cause an impairment in the function of the great sympathetic and thus

bring about a disturbed equilibrium in the affective life. In the degenerate, the affective life is easily upset because it constitutes the bulk of their psychic life: the higher the intellectual structure of a subject the less marked is his affective condition; this explains the marked affective part of nature in the degenerate who are nearer the low scale of intellectuality; anguish and anxiety is therefore easily brought about in these subjects.

General Consideration of Anxiety, and its Clinical Forms.—The shallowest degree of anxiety is disquietude. All degrees of disquietude up to extreme anxiety can be met with in the normal state, but there is always some reason for these conditions; in the insane, these conditions take place without any apparent reason. Conditions which may give rise to various degrees of anxiety are: disturbances of the general sensibility, motor disturbances, circulatory, gastric, respiratory and secretory impairments; anomalies of sentiment and cerebral defects. The mode of reaction in these states of anxiety depends on the condition of the subject: it may lead to violent acts or else completely paralyze all reactive manifestations.

Anxious melancholia is the most marked representation of the form of pathological anxiety; it may be met with in the various forms of psychic diseases: in mania, simple melancholia, folie à double form, in the psychoses of intoxication, in general paralysis and in other affections.

ERNEST DUPRE.—Auto-Accusers from a Medico-Legal Standpoint: The auto-accusation considered here is that concerning individuals who declare themselves guilty of some misdeed before administrative or judicial powers. In legal medicine, auto-accusation is synonymous with auto-denunciation. This may be met with in conditions of melancholia, in the mentally degenerate, in those suffering from toxic psychoses, in those afflicted with psychoneuroses and in the epileptic; the dementes are apt at times to denounce themselves. The pathological motives for the auto-accusations are characteristic of every disease which is at the root of the disturbance. The auto-accusations may take place under the following forms:

1, a crime that has not taken place; 2, a real crime, but one that cannot be imputed to the auto-accuser; 3, a real crime that can be imputed to the auto accuser; and 4, a crime committed by the auto-accuser, but the deed is considerably exaggerated under pathological influences of an impulsive nature.

It is self evident that in such cases the intervention of the psychiatrist is of the utmost importance in the matter of judicial administration.

PROFESSOR JOFFROY AND E. RABOT.—Two Brothers Affected with General Paralysis; Both Come from a Degenerate Family: Both brothers presented distinct signs of general paralysis. One of the patients had a history of syphilis and alcoholism and the other overworked considerably and had had malaria. The family history is distinctly that of degenerates: The maternal grandfather was an alcoholic and died insane; his daughter,—the mother of both patients, was an epileptic; she died a dement, at the age of 48 years; she was a hemiplegiac and an aphasic during the last six years of her life; she had had thirteen children and all of them, save one, are insane. The autopsies performed on the bodies of the two brothers confirmed the diagnosis of general paralysis.

The point of interest in these cases is the fact that two brothers, belonging to a degenerate family, died of the same disease although they had been exposed to different exciting agents.

An interesting analysis of the various and complex workings of heredity and of exciting causes follows in the text of the paper.

KERAVAL AND RAVIART.—On the Condition of the Eye-Ground in General Paralytics; the Initial Lesions: Fifty-one general paralytics were examined ophthalmoscopically and the following are the results of these examinations: forty-two of the patients presented lesions of the eye grounds; only those who were in their periods of intermission did not present any lesions. In seven cases, which had reached advanced stages of the disease, the following lesions were found; white papillary atrophy, in five cases; grey atrophy, in one case, and posterior bilateral sclerochoroiditis without myopia, in one case. Two autopsies made on the bodies of patients who died fifteen days after the ophthalmoscopic examination enabled the authors to verify the diagnoses made during life. A comparison between the clinical symptoms and the corresponding microscopic evidences shows that there exists a parallelism between the two,—marked lesions correspond to marked clinical symptoms and slight lesions correspond to slight clinical symptoms.

ERNEST DUPRE.—Pseudo-Pregnancy in General Paralysis: It is a well known fact that general paralytics often imagine themselves to be pregnant; it is well known that hysteria plays an important part in this pathological manifestation; MM. Dupre and Pagniez have not come across any cases of this character in subjects free from hysteria. The case which they presented was a woman, thirty years of age, who had distinct somatic and psychic symptoms of general paralysis; she suffered, in addition, from

temporary mental confusion, hebetude and from obtusion of the intellect. The imaginary pregnancy was expressed by a most characteristic external appearance of pregnancy at an advanced stage; not only was the volume and form of the abdomen of significant shape, but the gait was also specific of the condition in which the patient imagined herself to be. A direct examination brought out the fact that the genital as well as the perigenital organs were in perfectly normal condition. When informed of the fact, the patient only smiled incredulously and kept up her belief in her pregnancy for some weeks subsequently. The lying-in linen was meanwhile prepared and the menstrual flow did not appear until the expiration of the normal term of pregnancy; the abnormal size of the abdomen disappeared some time afterwards.

MM. DUPRE AND PAGNIEZ.—Precocious General Paralysis in a Subject with Mental Debility and Hereditary Syphilis: The patient inherited syphilis from her mother; mental debility was present before general paralysis manifested itself; the latter disease lasted three years and the patient died from general paralysis at the age of twenty-three years. The lesions found at the autopsy fully justified the diagnosis of general paralysis. This is an additional case to those reported by Toulouse and Marchand and confirms once more the rôle of hereditary syphilis in the causation of general paralysis; besides, this case also shows the frequency of occurrence of general paralysis in those subject to mental debility.

DEVAY.—Treatment of General Paralysis: Seventy-two general paralytics have been subjected to mixed anti-syphilitic treatment: injections of calomel and progressive doses of iodide of potash, until the dose was twenty grams per day. The following results were obtained in twenty-one cases: The somatic signs disappeared and the intellectual disturbances were also improved to a slight degree; in some cases the intellectual disturbances were even markedly improved; in some of these cases the period of intermission was prolonged indefinitely, with the improvements as above described. These results should encourage the employment of this mixed treatment, particularly because general paralysis is a syphilitic disease. Dr. Marie recommended the use of iodide by injection and said that there was no danger in this method of treatment.

LEGRAIN AND GUIARD.—The Recidivist Alcoholic: Considering the great frequency of recidivism among the alcoholists, it becomes necessary to make some suitable provision for the prevention of the repetition of the disease. At Ville-Evrard,

the proportion of recidivist alcoholists is about twenty-five per cent. This frequent repetition of the disease is costly to society as well as dangerous to all who come in contact with these morbid subjects before their isolation. The remedy for the evil is as follows: the alcoholist should be treated at an early date after the nature of his affection is known; moral treatment is of considerable advantage in these cases; a law should be passed, enabling the proper authorities to isolate these patients at the earliest moment; the dangerous recidivist should be forcibly detained in the asylum for a certain length of time and he should be made to pay a heavy penalty whenever this is practicable; those who enter in a condition of alcoholic delirium should be treated as if they were chronic recidivists; a special hospital for the alcoholists should be constructed; the work of temperance societies should be encouraged outside, as well as inside, these hospitals.

BOURNEVILLE.—On the Remote Consequences of Surgical Treatment of Idiocy and of Epilepsy: Epilepsy operations are generally followed by immediate improvement, but the attacks reappear later on in severer form than they presented themselves before the operation, and the intellect undergoes a rapid disintegration. The results are quite as unsatisfactory in cases of Jacksonian epilepsy; one need only observe the cases during a period of some years to realize the truth of this statement. Traumatic epilepsy alone seems to be amenable to surgical treatment; to obtain good results it is necessary to operate early, however.

As regards idiocy, surgical treatment came into vogue on account of the erroneous theory of premature synostosis in this disease. To-day, this theory has been abandoned.

Obregia has been interested in five epileptics, who, a few years ago, had been subjected to resection of their cervical sympathetic nerves. The fits disappeared after the operation, but returned again later on, being quite as numerous and of as much intensity as they were before the operation was performed. It was necessary to give them large doses of bromide, as high as fourteen grams per day, in order to keep the fits under control. Two of these patients got well, two still remain under treatment and one died during an attack.

BONNET.—The Cure Through Disintoxication: Auto-intoxication is a recognized factor in the causation of mental diseases; it is important, therefore, to disinfect the digestive tract of the insane as much as is possible; a milk diet is also of advantage in these cases; purgatives, diuretics and injections of serum are of considerable value in the treatment of these disturbances.

CASTIN.—Delirium of Negation of Cotard is not Simplicy Syndrome: This disease is a distinct and individual affection, having its special etiology, symptomatology, evolution and prognosis; the prognosis is grave, as the total number of deaths is twelve out of thirty-two cases.

CROQ.—On the Katatonic Symptom: The German authors have caused some confusion by their indiscriminate application of the term katatonia to various affections; katatonia is not even a syndrome; it is rather a symptom that may be met with during the course of various mental affections. A typical case of katatonia in a hysterical subject was presented; an analysis of the urine showed that there existed a marked disturbance of the general nutrition: there was a decrease of the quantity of urine, hyperchloruria, hypophosphaturia and a diminished amount of secreted urea.

The point of interest in this question is to find out whether katatonia is due to nutritive disturbances or whether these disturbances are the results of the stupor. Katatonia is accompanied by hypothermia, by cynosis of the extremities, and by lowering of the circulatory and the respiratory functions; these general trophic disturbances are rather the consequences than the causes of katatonia; it is possible that the same is true of the urinary disturbances.

PICHENOT.—On Sudden Death from Cardiac Rupture in Dements: It is admitted, in works treating of this question, that the principal cause of cardiac rupture in the dementes is fatty degeneration of the myocardium and impairment in the condition of the coronary arteries. The cause itself of the fatty degeneration has not been analyzed, however.

Dementia may be considered as a cause; at least, the four cases of Pichenot seem to point to the truth of that supposition. These four cases are classic: there was sudden death, and at the autopsy were found fatty degeneration of the myocardium in all the cases; the coronary arteries were affected in two cases.

Quain called attention in 1850 to the influence of emotional troubles on fatty degeneration of the myocardium; he insisted particularly on the influence of moral depressive impressions and prolonged worry in the causation of degeneration of the organs. Pichenot explained that these emotions act by causing enfeeblement of the mental faculties or, in other words, dementia. The four patients were dementes, and the cardiac alterations were due

to their demential condition. Three of these patients were below sixty years of age and one was below seventy years of age.

Odriozola states in his thesis, Paris, 1888, that of one hundred and fifteen cases, death was caused by cardiac rupture in ninety-four instances, after sixty years of age. The difference of ages found by the two authors is due to the fact that Pichenot reports insane cases, in which myocardial degeneration is comparatively early in onset, as explained above; the cases reported by Odriozola were simple senile cases and the degeneration was naturally later in onset.

The author thinks that in the insane, cardiac rupture is frequent of occurrence and that autopsies should be practiced as often as possible on dements who die in asylums; these autopsies are often neglected because they are supposed to be uninteresting.

MAURICE FAURE AND LAIGNEL-LAVASTINE.—

A Histological Study of the Cerebral Cortex in Eighteen Cases of Meningitis:

The cases examined were those of tubercular meningitis with pneumococci, enterococci, and the bacillus of Eberth. Nissl's method was employed. The various categories of meningitis are not differentiated here because they all have a similar physiognomy, so far as the cortical lesions are concerned. The cortical lesions observed were irregular and not constant; besides, a similar condition of the meninges may be accompanied by dissimilar cerebral lesions. As a rule, the cortical lesions correspond exactly to the meningeal involvements; the severity of the lesions generally corresponds to the degree of advancement of the inflammation. The interstitial lesions were: erasions or contractions of the cerebral tissue; the vessels were dilated, filled with small round cells; the capillaries of the granular layer and of the upper part of the cortex were particularly affected. The infiltration penetrating into various depths of the tissue in some parts, while others remained free from it. The cellular lesions are the following: The large cells are generally impaired; they lose their usual shape and become globular, and their chromophil bodies diminish in size as well as lose the distinctness of outline. The cellular nucleus remains in its place, but its distinctness of outline is impaired; the cellular contour itself becomes irregular in shape and its prolongations are thinned and pale. This condition is not characteristic of meningitis, as one finds it also in general paralysis. These lesions may be situated at a distance from the focus of inflammation, but they predominate in its vicinity.

The lesions here described were very marked in four cases,

slightly marked in eight cases and almost absent in six cases. In these six cases the meningitis was of a slight nature, having lasted from twenty-four hours to two days, during the course of chronic pulmonary tuberculosis in its last stage. On the contrary, in the four cases that presented the marked lesions, the meningitis, of tubercular nature, was classic in evolution.

OBREGIA.—On the Nerve Supply of the Vessels of the Cerebral Pia Mater: It was shown on preparations that the polyaxonic cells of Ramon y Cajal, which belong to the molecular layer of the cerebral cortex, send out ramifications of their axis cylinders exclusively to the vessels of the pia mater, forming around these vessels a rich nervous plexus. The peripheral disposition of these neurones forms a vaso-motor system. It is logical to conclude that the superficial polyaxonic cells of Ramon y Cajal are destined to form a vaso-motor system for the vessels in the superficial cortical layer and in the pia mater. It can easily be understood that when the large cells in some motor area enter into action, the superficial cells that have an important vaso-motor function also enter into action.

G. DURANTE.—On the Histological Process in Muscular Atrophy: Simple muscular atrophy only is considered, such as is observed during the course of an affection of the nerve supply, the nervous centres and in progressive myopathies. Muscular atrophy is the result not of molecular resorption but of a complex process; this process sets in by a true inter-cellular anarchy; in consequence of a disturbed harmony between the different parts of the striated fibers, there results hyperplasia of the sarcoplasma; the latter is then transformed into embryonic cells which are later transformed into connective tissue cells and finally into fatty cells. When various other degenerations of the muscle cells take place, they are due to super-added causes, such as infectious diseases, cachexia, digestive disturbances and various other infections. All the amyotrophies are due to the same histological process of transformation; there may be a difference in the distribution of the lesions and in the rapidity of their evolution.

LAIGNEL-LAVASTINE AND HALLION.—On the Local Cutaneous Circulation of the Hand in Organic Hemiplegia and Raynaud's Syndrome: The activity of the surface circulation in the hand is judged by the appearance of redness after a white spot has been caused by simple pressure. The difference of the duration before reaction can be seen enables one to judge whether the redness is caused by vaso-motor paralysis or by active

vaso-motor dilatation. The time of reaction is shorter on the paralyzed side when the test is made the day following the apoplexy that has caused the hemiplegia. As the days go on, this time of reaction becomes gradually longer on the affected side; it then becomes equal on both sides and finally ends by becoming longer on the affected side.

MAURICE FAURE.—**On the Origins of Tabes:** Syphilis may be the cause that predisposes the subject to the disease; as a rule, there seems to exist an additional cause in the majority of cases; the grip, infectious rheumatism, blennorrhagia and other affections generally excite the onset of the disease. It does not seem rational to incriminate syphilis alone as a cause in the production of the disease. As regards the special individual predisposition, the question should be closely examined; it seems that all subjects affected with locomotor ataxia have a great similarity in their aspects, their natures, their habits, their physical constitutions and their mental conditions.

R. CESTAN AND DUPUY-DUTEMPS.—**The Argyll-Robertson-Pupil:** This sign is found only exceptionally during the course of either mental or nervous diseases which are not characterized by general paralysis or by locomotor ataxia. When this sign exists, there may be some syphilitic infection; the question of the relation of this sign to syringomyelia and to hypertrophic interstitial neuritis must be considered with some reserve. Therefore, the presence of the Argyll-Robertson pupils limits us to the suspicion of the presence of two diseases: syphilitic infection or general paralysis. When this question faces us we must look for an answer to pathological anatomy. When the supposition is made that the presence of the Argyll sign indicates that the patient suffers from tabes, the objection may be made that syphilis is not always the cause of this disease even when the Argyll-Robertson pupils are present; it can be objected also that the Argyll sign is rarely present in syphilitic affections of the nervous system; except in tabes and in general paralysis. Under such conditions, one should be guided by the histological indications. From a practical standpoint, however, the loss of the pupillary reflexes to light is a proof that a syphilitic infection exists.

HENRY MEIGE.—**Giants:** The author deprecates the action taken by a certain individual who has set aside a given sum of money as a dower for persons above the average size who wish to marry in order to perpetuate a giant generation. Histories of giants are given, showing that these subjects are generally physical degenerates. All that is known of Goliath, for instance, is his

high stature; another biblical subject is said to have had supernumerary fingers,—which constitute physical stigmata of degeneracy; Donnat saw a giant in Milan who occupied two beds adjusted together lengthwise; regardless of his enormous size he was unable to hold himself on his feet. William Evans, the giant porter of Charles I, had no physical force; Cromwell's porter, also a giant, became an inmate of an asylum for the insane; of O'Brien it is said that he "was like an enormous sick child who had grown too fast." Garnier points out the awkwardness of these subjects. One could multiply examples in support of the truth that giants are pathological beings. There may exist some exceptions to this rule, but a combination of physical and mental giantism is quite rare of occurrence. The reverse is generally the rule. One is easily impressed by the similarity that exists between the defects found in the giants and those observed in acromegalic subjects. It is well known that giants very frequently become acromegalic. Sternberg showed by statistics that fifty per cent. of giants become acromegalic. Clinically, acromegalia never precedes gigantism, but it follows it in fifty per cent. of the cases. When the two conditions were associated, gigantism always preceded acromegalism. It seems irrational, therefore, to endeavor to perpetuate a race of giants, when they are pathological beings.

REGIS.—Psychiatry and the Theatre: This subject was chosen for the presidential address and it is full of interesting analysis of literary types as pictured by the various writers of drama. The faults as well as the merits of writers are pointed out in the description of their insane heroes or heroines.

The next congress of alienists and neurologists of France and of the French speaking countries will be held at Brussels. Francotte was appointed president, and Crocq will be secretary.

Klippel is to make a report on the histology of general paralysis; Trenel is asked to report on the treatment of insomnia during the course of mental diseases and on metal agitation. Claus will be assigned the task of reporting on the administration of hospitals for the insane.

SPASMODIC PARAPLEGIA IN A CASE OF COMPRESSION, EQUIVALENT TO A SECTION OF THE SPINAL CORD, IN ITS DORSAL REGION.—DRS. E. BRISSAUD and E. FEINDEL publish this case. The authors make some reserve regarding Van Gehuchten's idea that the abolition of the reflexes found in flaccid paraplegia, due to a transverse lesion of

the spinal cord, is due to an anatomical or functional interruption of the spinal fibres at the point of compression. Further, they disagree with the same author, who states that when the spinal compression is incomplete, in the initial stage, spasmodic paraplegia exists, instead of a flaccid one, and the abolition of the reflexes is replaced by a marked exaggeration of the same. The authors agree that the latter form of the affection is almost always characteristic of Pott's disease. As regards the spasmodic form, however, there are cases which remain spasmodic from the beginning to the end of the disease. This is true not only of cases of Pott's disease, but also of those of total transverse myelitis equalling a complete section of the cord, and which, consequently, is characterized by an anatomical and functional interruption of the spinal fibres, at the point of compression. Not only are some of these paraplegias spasmodic throughout the course of the disease, but they are also characterized by permanent contractures and considerable exaggeration of the reflexes and the ankle clonus. A case is cited to support this view. The autopsy showed that in this case of Pott's disease the cord was so diseased that its section was equivalent to a complete section. It is concluded, on the strength of this additional case, that spasmodic paraplegia may persist in cases with slow destruction of the segments of the dorsal region of the spinal cord, where the anterior horns, the cells of Clarke's column and the nerves are not impaired after the initial lesion, by being situated below that lesion. Partial sensory paraplegia may be produced under similar conditions, although the fact presents greater difficulty in explanation. The sensation that persists is elementary, lacking the differentiation of heat, cold, pain or contact. The patient is aware of some sensation on the cutaneous surface (paralysis of sensibility), but he cannot distinguish the character of the contact. It is possible that this sensibility is conveyed through unusual avenues; this may also explain the delayed sensibility. The arguments regarding various theories in this connection and the analyses of similar cases in this paper are instructive. (*Archives de Neurologie*, Jan., 1902).

AUTO-INFECTION AS A CAUSE OF DEVIATION FROM THE NORMAL PSYCHIC STANDARD.—DR. ANDRE POPOV: 1,—the accepted division of causes of insanity into predisposing and exciting does not correspond to clinical reality; 2,—psychopathic manifestations are generally due to a whole train of causative agents; under exceptional circumstances only do we find one specific and exclusive cause of insanity; 3,—although much progress has been made lately in the

domain of research in histology, chemistry, bacteriology, psychology and other sciences relating to psychiatry, this knowledge cannot as yet be utilized practically in the matter of understanding the psychic phenomena in life; 4,—every degree of activity in the neurones is accompanied by nutritive changes, which accumulate gradually in the tissues and may, by their poisonous products, impair normal function before nutritive supply is exhausted; 5,—some forms of mental diseases may develop through a bio-chemical mechanism, so to speak, which leads to an impairment of psychic function by reason of poisoning with the products of retrogressive metamorphosis; 6,—auto-infections and infections are gaining place in the causative classifications of mental diseases; 7,—the auto-infections may be divided into various groups,—general, organic, special, etc., the form of the ensuing disease depending in some cases on the form of infection; 8,—some of the daring hypotheses on the question of auto-infection may lead to a closer study and more intimate knowledge of psychiatric diseases; 9,—auto-intoxications as etiological agents in the development of mental diseases stand in relation to the following facts: (a) some psychiatric affections develop under conditions which favor the onset of auto-infections; (b) there exists a clinical similarity between some psychiatric diseases and those which take place under the influence of some external poisoning; (c) the similarity of results obtained from the removal of some glands and the mental affections caused by diseases of the same glands (thyroid gland, etc.); (d) the results of urinalyses of neuro- and psycho-paths; (e) the occurrence of psychic diseases during or after the course of infectious diseases, which justify the supposition that the disease developed independently of the ultimate infectious products; (f) the results of some histological changes in the nervous elements caused by auto-infection; the late process of myelinization of the nervous tracts in the foetus, when the mother is subject to infection during pregnancy; (g) the beneficial effects of some therapeutic measures, which tend to diminish the degree of infection; 10,—if it is true that poisonous products are constantly being generated in the system, it is also true that the same organism is endowed with a protective system of prevention; 11,—no accurate measurements of the degree of auto-infection as yet exists in practice; 12,—the individual form of auto-intoxication co-existing with a psychic disease is not a proof of the infectious nature of the psychic disease; 13,—conditions of fatigue, transitory or permanent, are the results of bio-chemical changes under special conditions; 14,—the conditions of fatigue are accompanied by corresponding changes

of the nervous elements in the central system; 15,—the dependence of psychic disturbances on organic affections is seen in some cases of diseases of the liver, kidneys, etc. (*Roussky Medizinsky Vestnik*, February 15, 1902).

TRAUMATIC SECTION OF THE ULNAR NERVE.—M.

DELACROY: A child, 7 years of age, received a severe wound of the wrist by falling and striking a glass bottle. After the healing of the wound, the sensibility of the parts returned, but the muscles supplied by the ulnar nerve were paralyzed. A second operation was performed a fortnight later and the nerve was freed from cicatricial bands that had formed around it and the wound was again closed. Massage and electricity were resorted to with a view to remedying the muscular atrophy and paralysis; three months after the operation, the hand was still claw-shaped; an improvement was noticed only after the sixth month of persistent treatment. (*Journal de Neurologie*, Feb. 20, 1902).

EXTRA-DURAL SPINAL APOPLEXY.—DR. A. CO-

CHEZ: Extra-dural hemorrhage of the spinal cord is of rare occurrence in the adult. Hopkins reports one such case. The author's own case was that of a man, 45 years of age, who drank daily from 15 to 20 "absinthes." He sustained a severe fall, receiving many bruises of the body. On entering the hospital, he presented paresis of the lower limbs, trembling, amnesia and cerebral torpor. While under treatment, he suddenly fell in the ward, and when put to bed, it was found that he suffered from complete paraplegia, incontinence of urine and of feces and from hallucinations and melancholic depression; he died 13 days later. At the autopsy, a marked spinal hemorrhage was found outside the dura-mater, some sub-arachnoid oedema, interstitial nephritis of one kidney and the heart was characteristic of Bright's disease.

It is difficult to say when the hemorrhage took place, although it can be admitted that the traumatism had some effect on its appearance. The alcoholism and Bright's disease must have been strong factors in the onset of apoplexy. It is possible that the hemorrhage that took place at the hospital was one that followed a previous hemorrhage. Such cases are rather exceptional in occurrence. (*Archives de Neurologie*, Jan. 1902).

IS THE MIND AN ENTITY?—DR. H. H. STONER:

The mind cannot be considered as being an entity if we are to be guided by physiological reasoning. It cannot be said that sensation is the result of a physical process, while consciousness is not. Sensation arises in consequence of the disturbance of the

physical elements incident to the impact of a stimulus which has been transmitted to the brain over the afferent nerves. Sensation is certainly a psychic phenomenon, and if one of the phenomena of psychic life can be called into being by the intrusion of a physical force, is it not reasonable to suppose that all may be so manifested? The fact that we cannot tell just what physiological process takes place within the psychical cells at the moment when consciousness emerges as a necessary product from sensation is no reason for asserting that it is not essentially a physiological product. The question is not furthered by saying that consciousness is an entity, a reality, a substance without spatial relations, and that it has an existence outside the functions of the brain.

Mind and body are related because neural activity and the bodily functions are interdependent. It is true that many functions are going on in the organism of which we are unconscious; but when these stimuli become so intense that they overflow their boundaries, or when the reflex paths become incompetent to transmit the volume of stimuli, a portion of it switches off to the cerebro-spinal system, and arriving in the psychical precinct, gives rise to a peculiar sensation, which we are pleased to call an emotional state. And, *vice versa*, when mental impressions arise of such intensity as to overflow the carrying capacity of the cerebro-spinal system of nerves, the excess passes off into the sympathetic nervous system, upsetting the normal balance of tissue metabolism, which, on being retransmitted to the brain, is there again interpreted as an emotional feeling. In this way are mind and body related. Emotional feelings and the esthetic sense arise in consequence of stimuli enacted in the tissues of the body. The relation between the sympathetic functions and the manifestation of emotional states is well exemplified in the blush of shame, the pallor of fear and the flush of anger. The phenomena are so clearly dependent on outside stimuli for their manifestations that it seems like a waste of words to argue any further on the question. If we are ever to understand the physiology of the mind, psychology and theology must be divorced. If we locate the soul of man in the brain and assign to it mental attributes, we erect a barrier which says to physiological psychology: "Thus far shalt thou go and no further." To the medical man the mind must be looked on as purely a physiological product—a product capable of being warped and bent by its environments. A mind made of such material may be influenced and diverted into channels of mental and bodily health, but a mind whose essence is distinct and separate from the bodily func-

tions can not be reached by human means. (*Medical Record*, March 29, 1902).

ANAESTHESIA OF THE SENSORY AND MOTOR NERVES.—M-ELLES J. IOTYEJKO AND M. STEFANOWSKA: Inhalations, injections, or baths of anaesthetic agents do not produce anaesthesia of the nerves. In the frog, the sciatic nerve retains its normal excitability after large doses of ether have caused suspension of respiration and circulation. Dogs and guinea-pigs present similar phenomena. The peripheral neurones are more resistant to the effects of anaesthetics than are the central nervous centres. Total or partial nerve-anaesthesia can be obtained, according to whether the whole or part of a nerve is introduced into a glass globe containing an anaesthetic. The decreasing excitability of the nerve is measured by means of an electric battery. The central end of the nerve loses first its excitability. The sensory power is lost first and the motor next; the motor fibres regain activity first. Chloroform is less volatile and more toxic than ether. In surgical, as well as in experimental anaesthesia the effect of the anaesthetic is local; in the former case it is limited to the cerebro-spinal axis. (*Journal de Neurologie*, Feb. 20, 1902).

ON THE MODIFICATION OF REFLEXES IN SPINAL TRAUMATISMS.—DR. O. LAMBRET: The question of the spinal reflexes is still a mooted one. In traumatic cases it is of great importance to make a diagnosis regarding the inflicted lesion, but one can hardly be guided positively by the presence or the absence of the reflexes. Physiological experiments demonstrate the existence of reflex centres, at various heights, in the spinal cord. In the dog, a transverse section of the spinal cord caused an exaggeration of the reflexes below the line of the section. Bastian claimed to have found that sections of the cord, at the lower cervical or upper dorsal regions, give diametrically opposite results in man and in dogs: in man, there was abolition of the reflexes; he held the idea that this absence spoke in favor of a complete section through the thickness of the cord. Bastian, Bowlby, Jackson and Van Gehuchten then demonstrated that the reflex centres were situated not in the cord,—but in the cerebrum and the cerebellum. The exact localization of the centres in the brain remains an open question. The process of evolution may have brought about the change of seat of the reflex centres in man, as contrasted with that found in animals. However, there are some contradictory clinical cases regarding this question.

M. Delbet admits that very often there are seen cases of trau-

matic sections of the cord in man that are characterized by abolished reflexes. The author observed a case of fracture of the second dorsal vertebra in a young man who presented abolished reflexes. M. Walther presented a case of a young woman, whose spinal cord was cut through the entire thickness by the passage of a bullet from a revolver, at the fifth dorsal vertebra. The examination by Dr. Brissaud showed the following:

Complete anaesthesia of the entire lower part of the body, up to a line at the level of the nipples. Anaesthesia to touch, pricking and temperature. There was, on the contrary, a marked area of hyperesthesia above the mammillary line.

Complete motor paralysis in the entire zone of anaesthesia.

Complete abolition of the reflexes of the lower limbs,—nevertheless tickling of the sole of the foot caused slight movements of flexion of the toes.

The toe movements show that the cord had not lost completely its excito-motor power; it was only very much decreased. Seven weeks after the accident, it was possible to provoke slight patellar reflexes.

Another case, in Prof. Folet's ward, received a blow on the head by falling to the ground. He presented a hemiplegia of the lower limbs, complete anaesthesia to the mammillary line and abolished patellar reflexes. At the autopsy, it was found that there was a hemorrhagic effusion at the level of the third dorsal vertebra and it extended to the fifth. This case shows that Bastian's rule is too exclusive, because a simple compression of the cord may cause abolition of the reflexes. It is therefore necessary to resort to an explorative incision when an accurate diagnosis is urgent. (*L'Echo Medical du Nord*, Feb. 2, 1902).

CORRECTING SPEECH DEFECTS.—MR. OLIVE E. D. HART: The method of correcting speech defects is entirely natural, as applied by the author. The first step consists of the correction of the breathing; then, the vocal organs should be put in a natural position. Many speech defects could be done away with if "baby talk" were not encouraged. Most pupils generally have a flattened chest and the head in a position independent of the body. In order to breathe naturally the head should be erect and the chest high. The principal form of breathing should be abdominal. Bed exercise is helpful; it consists of lying flat on the back, with a pillow under the head; the chest is thus filled with air; the mouth should be closed, the breathing taking place through the nose. The process of speech is impeded if breathing is done through the mouth at the same

time. Vocalization is another helpful element, teaching how to pronounce vowels or vocal consonants. The subjects generally substitute some letters for others, not only in speech, but also in writing; this shows that mental inattention governs the scene to some extent. Every case generally requires special methods; individual study is of considerable importance. (*Brooklyn Medical Journal*, April, 1902).

STATE CARE OF THE INSANE.—DR. L. J. MORTON: Various questions regarding the care of the insane are touched on. Segregation seems to be favored by the author; cottage life is more conducive to recovery than are crowded wards in large buildings; these make the surroundings most unnatural and bewildering to some patients. Insanity is on the increase, and immigration is largely responsible for this. (*New York Medical Journal*, April 12, 1902).

BOOK REVIEWS.

LE LIQUID CEPHALO-RACHIDIEN.—By J. A. SICARD, Chef de Clinique, Salpêtrière. With a preface by Professor Brissaud, *Masson*, Paris.—The practice of lumbar punctures in clinical work has become of such importance that scientific contributions to the study of the cerebro-spinal fluid are most welcome at the present stage of our knowledge in this line of work. A concrete description is given in this book of the technique used in making lumbar punctures; therapeutically, an analysis is made of the value of sub-arachnoid injections and of the aspiration of the cerebro-spinal fluid; these chapters are followed by a study of the subject from the histological and the physiological standpoints; finally, the cerebro-spinal fluid is considered from its physical, chemical, bacteriological and cytological points of view.

In the chapter on therapeutic indications for lumbar punctures the following subjects are treated of: the results obtained in hydrocephalus, chlorosis, uremia, cerebral neoplasms and especially in bacterial, non-tubercular meningites. The author experimented with the following substances for making sub-arachnoid injections: normal artificial serum, air, oily substances and tetanic toxins. The tolerance to these substances is described and the treatment of tetanus by sub-arachnoid injections of serum is considered; space is also given to the consideration of the question of cocaine injections. Although every chapter in this book is of much importance, they cannot all be analyzed here for the reason of lack of space. The chapter on cytodiagnosis is most valuable; the technique of this method is concretely described and important clinical data are furnished from the standpoint of accurate diag-

noses in difficult cases of meningeal inflammations, acute and chronic.

A great deal of importance is attached to the presence or the absence of lymphocytosis and of polynucleosis in the cerebro-spinal fluid. Thus, when tubercular meningitis is uncomplicated by other diseases of the cerebro-spinal axis, the presence of lymphocytosis is generally the rule; in simple bacterial meningitis, on the contrary, polynucleosis is more predominant. Indications are given regarding possible errors in diagnosis of such cases and illustrations are cited, showing how to avoid erroneous conclusions. In acute syphilitic meningitis, lymphocytosis has been found to be marked.

LYMPHOCYTOSIS IN GENERAL PARALYSIS.—The author examined the cerebro-spinal fluid of seventeen cases of general paralysis. In fifteen of these cases the lymphocytosis was considerably above the normal. Nine of these fifteen patients acknowledged having suffered from syphilis, six cases claimed to be free from the disease and eleven presented Argyll-Robertson signs. Special interest is attached to the examination of the cerebro-spinal fluid in the remaining two cases: Eighteen months before it was positively recognized that they were suffering from general paralysis, the author had occasion to practice lumbar punctures on them; these patients were then said to suffer from neurasthenia and they claimed to be free from syphilis. The examination of the cerebro-spinal fluid, however, showed an increased lymphocytosis.

In tabes dorsalis lymphocytosis is also increased above the normal, particularly after prolonged attacks of shooting pains. The lymphocytosis is more marked in the earlier than it is in the latter stages of the disease.

Concluding this important chapter the author says: Psychiatrists who have studied the cerebro-spinal fluid in the insane have concluded that lymphocytosis is absent in the simple psychoses (mania, melancholia, mental confusion and dementia precox); this knowledge only increases the importance of the presence of lymphocytosis in general paralysis, the diagnosis of which is so often very difficult to make. It is within the province of the alienist to study up the question regarding the lymphocytosis in acute delirium; as is well known, many authors have ascribed this disease to the action of various bacteria. The cytodiagnosis should, therefore, clear up and explain the etiology and pathogenesis of this still obscure syndrome.

The volume is introduced by Professor Brissaud with an embryological study of the development of the sub-arachnoid space.

It is very rare to find such a small contribution, 192 pages, so replete with important scientific as well as with clinical information.

LA LOGIQUE MORBIDE, DE L'ANALYSE MENTALE.

Part I; N. VASCHIDE, chef des travaux, Laboratory of Experimental Psychology, School of Higher Studies, and CL. VURPAS Interne at the Villejuif Asylum. *F. R. De Rudeval and Co.*, Paris, 1902. Psychology is becoming more and more a concrete science and its exponents are beginning to base their arguments on clinical facts rather than on theoretical reasoning; the latter method has proven to be unsatisfactory and the newer,—the clinical study of the question, is rapidly gaining ground. The first chapter of this work deals with mental analysis in normal man; this is naturally an introductory element to the exposition of the subject properly speaking; this normal analysis then serves as a point of comparison with the abnormal mental analysis found in the pathological subject.

The study of mental analysis in the morbid subject properly speaking is considered under four headings. 1,—somatic introspection, a gradual and progressive concentration on the examination of the material self leads on to delirious interpretations. 2,—mental introspection is the next subject of study; the individual directs his entire activity on the examination of his mental self, and confounds his mental analysis indistinctly with the association of ideas having no bearing on his subjective state. 3,—delusional extrospection; in this condition the subject analyzes every incident of life, everything that comes to his notice, such as sounds, gestures, signs, etc. Finally, 4,—morbid analysis of the cosmic surroundings; the authors call this analysis "metaphysical delirium."

The authors are striving in a most commendable manner to simplify the understanding of the mechanism of cerebration in the insane and support their statements by demonstrations from the hospital wards.

A complimentary introduction is made by Professor Th. Ribot, Member of the Institute of France.

PSICHIATRIA (*Clinica Psichiatrica e Antrophologia Pathologica*). Opere Complete, Vol. II. DR. SERAFINO BIFFI: *Ulrico Hoepli*, Milan, 1902. The complete works of this author comprise five large volumes, and every volume consists of some four hundred and fifty odd pages. It is generally difficult to do justice to such works in an analysis of the limited extent required in a periodical. One must limit one's self to the mak-

ing of suggestions only regarding the real value of such volumes. The studies in the volume here examined cover various subjects connected with clinical work in psychiatry. Thus, a large chapter is devoted to the consideration of stuporous melancholia; other subjects treated of are brachial neuralgia, and cretinism, some two hundred pages being devoted to the consideration of the latter; an interesting report is made of a case of a needle imbedded in the cardiac muscle; there is further a study of aphasia, amnesia and, finally, a series of articles relating to administrative asylum business, to the progress of psychiatry, to vaccination in asylums, etc., etc. The reading of the volume is highly interesting and its contents very instructive.

FISIOLOGIA E FISIOPATOLOGIA SPERIMENTALE.—

Vol. II., DR. SERAFINO BIFFI: This volume is similar in character to the preceding one in so far as the easy grouping of subjects is concerned. It contains interesting studies of the great sympathetic and vagus nerves, the lingual nerves and experimental studies on the glosso-pharyngeal nerve, and the nervous supply of the small intestines. An exhaustive article of two hundred pages is devoted to the study of the inoculation of tuberculosis. Various other general medical subjects are treated of and the volume is concluded by a series of commemorative addresses on the lives of distinguished scientists who were the author's friends and collaborators.

PSICHIATRIA (Tecnica Manicomiale), Vol. III., DR. SERAFINO BIFFI: The title of this volume is indicative of its contents: The entire work is devoted to the question of the housing and the administrative interests, connected with the insane. An extensive monograph is taken up with a eulogy on the eminent Belgian psychiatrist, Guislain, whose life was devoted entirely to the study of insanity and the provision of methods to improve the treatment and handling of the insane. The volume may be said to constitute a whole encyclopedia of information relating to the handling of the insane in the various civilized countries. The question of colonization of the insane is considered at length and is most instructive in its details.

BOOKS AND PAMPHLETS RECEIVED.

Dr. Serafino Biffi. OPERE COMPLETE. Ulrico Hoepli, Milano, Italy.

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SUPPLEMENT A L'EXPOSE DES TITRES ET TRAVAUX SCIENTIFIQUES DU DOCTEUR MAGNAN.

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DEMENTIA PRÆCOX.

By DR. E. BLEULER, *Professor of Psychiatry, University of Zurich.*

On page 175, May, 1902, of THE JOURNAL OF MENTAL PATHOLOGY, Serbski criticises the definition of dementia præcox as given by Kraepelin. The main objections raised by the author are the following:

1. The termination of the disease is not characteristic and may lead to various terminal psychic states.
2. There hardly exists any one characteristic sign of dementia præcox. It is not even necessary that dementia show itself.
3. The disease may manifest itself at middle age and even at a later period.
4. The etiology, anatomy and pathology do not seem to be the same in all the psychic varieties brought under the heading of dementia præcox.

My twenty years' experience has taught me to delineate the disease in the same manner as Kraepelin has done, with the exception that I have not included the paranoidal forms quite as extensively as the latter author has done. Now I think, however, that Kraepelin is right.

So far as I can judge, the symptomatology of dementia præcox is sufficiently definite to enable one to make an unerring diagnosis of this disease in a manner similar to that in which a diagnosis is made of pneumonia or of typhoid fever.

When Serbski says that the disease may terminate variously, he is right in so far as his own grouping of the forms of this affection is concerned. I think, however, that diseases that terminate differently do not belong to the same pathological group. On the contrary, diseases of similar termination may be grouped together symptomatologically. Under these conditions, a short period of observation of the psychoses enables us to diagnose them as correctly as we do the well familiar affections of purely physical nature.

Serbski further says: "According to Kraepelin, the characteristic trait of dementia præcox is its mode of termination. Kraepelin himself states that about twelve per cent. of recoveries are met with in this affection." The latter statement seems to Serbski to be contradictory to the fundamental trait of the disease. The author forgets, however, the following:

According to Kraepelin, the disease is apt to be arrested in its course at any one of its stages. When this arrest of the progress of the affection takes place at an early date, the patient may be considered as cured, as an insignificant psychic scar is not easily apparent. Practically speaking, indeed, such patients are cured, although from a theoretical standpoint the matter may be questioned. An analogous condition may be found in organs that have been affected with physical diseases. Thus, in some cases of healed up pulmonary tuberculosis, it is not always possible to point out the scar. Yet no one doubts the existence of such a scar. One should not be more stringent in requiring object proofs in cases of psychic affections than one is in those of familiar pathological conditions.

Further, Aschaffenburg, from his observations of cases similar to those of Kraepelin, has been led to doubt the curability of dementia præcox, and, according to my own observations, there are patients who are apparently cured and able to attend to their daily work as usual, but who, on close examination, prove to be cataleptic.

Again, according to Kraepelin, most of the cured cases are apt to have one or more relapses and finally to become definitely demented; so that only a small number of cases remain to make an exception to the usual termination of the disease.

Yet I do not attach much importance to the latter fact. It is essential to know that the disease leads to dementia, but may come to a standstill at any period of its evolution. Should this arrest of evolution set in at an early date, the enacted psychic injury could pass unobserved. The patient is then considered as being practically cured, even though his psychic life be somewhat impaired. To postulate that the dementia in every case should be most marked, or at least well evident, is illogical and is not put forth in Kraepelin's works.

A most important fact is the following: *When dementia is recognizable, it is of a well defined variety and is proper to and characteristic of this disease.* It is not the dementia but the *kind of dementia* that characterizes the disease. There are many other forms of dementia, as congenital, senile, paralytic and epileptic. There is still another form of dementia. Periodic and paranoiac

patients, as well as sane people, who have lived for many years in hospitals or prisons, are liable to become subject to a slight psychic degeneration (*Verflachung*) that may sometimes be called dementia. These alterations are easily distinguished, however, from dementia præcox.

The differences between dementia præcox and all the other forms of dementia are many, and I shall here indicate only a few of them.

All cases of dementia præcox are characterized by a definite alteration of the emotions and in the association of ideas; this alteration is proper to this disease and is not met with in any other psychic affections.

It is very difficult to cover all cases with a short definition, yet I hope to explain myself by the following complementary remarks.

The emotional life, taken as a whole, becomes stunted: emotions are excited with much more difficulty and often not at all, and such emotions as still exist are often inadequate. This sign has been known long since. Whenever it was observed during the course of an acute psychic affection, the disease was expected to terminate in dementia.

It is a striking fact that these patients take little interest in things of importance to them; they are even indifferent to their own disease, to their future and to the fate of their nearest relations. Their indifference is also conspicuous in less important instances. Affective emotions phylogenetically acquired may hold out longer than do those of more recent date. Thus, for instance, a mother, who has become indifferent to all else, may still be capable of manifesting some affective feeling towards her children. *The feeling of anger is especially heightened in the majority of these patients who are obliged to remain in asylums.* Under the influence of delusions and of negativism, anger may even become the prevailing disposition.

At times, one single emotion remains, but may be quite inadequate and not in conformity with the ideas of the patient's mind: Patients may speak of the persecutions, to which they imagine themselves to be subject, not only with indifference, but even laughingly and with an air of boasting. They are quite as apt to cry over cheerful events, etc.

Such an alteration of the emotions in patients with an unimpaired consciousness and orientation is found in no other psychic affection.

In all forms of disease which are understood to come under the heading of "Manisch-depressives Irrensein" of Kraepelin the excitability of the emotions exists. During the attack, there is

either an exalted or a depressed condition. During the period of intermission, the effective disposition may be normal; when the condition is altered, it is apt to be more pronounced than in normal persons: the disposition of these patients is unstable, so that they easily pass from one mood to another, either marked depression or exaltation being the predominant feature. During the course of organic cerebral diseases (senile dementia and general paralysis) we often observe an apparent indifference of mood; this indifference is secondary, however. Complex ideas, such as affection for one's family, cannot be grasped as a whole by the patient and *for this reason* cannot be accompanied by appropriate emotions. When, however, the patient does conceive an idea, the corresponding emotion is excited; this is often done in a more or less exaggerated degree, although superficial in nature and of short duration. In paranoia (in Kraepelin's sense) the mood, as such, is normal; when it presents some deviations, they are due to normal reactions caused by false ideation. In the epileptic, the emotions are still excitable in every sense, in so far as conceptions are formed in their minds; this contrasts with what takes place during the course of organic affections; in the latter the affective function is more tenacious and of greater intensity.

The association of ideas in dementia præcox is disturbed in such a way that on the one hand the mental connections are interrupted here and there in an irregular manner; on the other hand, there appear thoughts, the connection of which with the preceding ones, either in part or as a whole, is not traceable.

The above statement is easily illustrated by the written composition of a young patient as follows:

“DIE BLUETEZEIT DER HORTIKULTUR.

Zur Zeit des Neumondes steht Venus am
Augusthimmel Aegyptens und erleuchtet
Mit seinen Lichtstrahlen Kaufffahrteiheisen,
Suez, Kairo und Alexandria. In dieser historisch
Beruemten Kalifenstadt findet sich das Museum
Assyrischer Denkmaeler von Makedonien. Dort
Gedeichen neben Pisang, Maiskolunen, Hafer,
Klee und Gerste auch Bananen, Feigen, Citronen,
Orangen und Oliven. Das Olivenoehl ist eine
Arabische Liqueur-Sauce, mit welcher die Afghanen,
Mauren und Moolemiten die Straussenzucht
Betreiben. Der indische Pisang ist der whiskey
Des Persen und Arabers. Der Perse oder Kaukasien
Besitz genau so viel Beeinflussungskraft auf

Seinen Elefanten, wie der Maure auf sein
Dromeder. Das Kammel ist der Sport der Juden und
Indien. In Indien gedeiht vorzueglich Gerste, Reis
Und Zuckerstock das heisst Artischoe. Die Brahmanen
Leben in Kasten auf Balaschistan. Die
Tscherkessen bewohnen die Mandschurei von
China. China ist das Eldorado des Pawnees.”

The above may be rendered in English as follows:

“THE FLOWERING SEASON OF HORTICULTURE.

At the time of the new moon Venus stands
In the August skies of Egypt whose rays
Illumine the mercantile harbors of
Suez, Cairo and Alexandria. In this historically
Celebrated town of the Califs there
Is the museum of Assyrian
Monuments of Macedonia. There grow, besides,
Plantain, mais, oats, clover and barley
Also bananas, figs, lemons, oranges and olives.
The olive oil is an Arabian liquor-sauce
With which the Afgans, Moors and Moslems
Carry on the rearing of ostriches. The Indian
Plantain is the whiskey of the Parsee
And Arabian. The Parsee or Caucasian
Possesses exactly as much influence
Over his elephants as the Moor does over his
Dromedary. The camel is the sport of the
Jews and Indians. In India there grows
Chiefly barley, rice and sugar cane, that is
To say artichokes. The Brahmins live in
Castes in Balachistan. Tcherkesses inhabit
Mantchuria of China. China is the
Eldorado of the Pawnees.”

In the above example it is apparent that there still exists a connection between the ideas expressed, in so far as they relate to the orient. Yet they appear as if they had all been mixed up in a bag, so to speak, and that the patient took them out as chance presented them. When asked what was the geographical position of Egypt, the same patient gave the following answer: “Between Assyria and Congo Free State.”

From a geographical standpoint, this answer is not wrong, yet it is quite peculiar. How, indeed, is one to connect an Asiatic land-

mark with the geographical limits in question? Who, when mentioning one of the newest States—the Congo Free State—would think at the same time of one of the oldest lands known? As can be seen, the mental associations are here peculiar and unusual. In more advanced stages of the disease it may become difficult to find any association of ideas at all. Under these circumstances, speech becomes an incomprehensible “Wortsalat” (Forel) and actions quite disconnected.

It is of interest to note that the disturbances of connection does not always exist to the same degree in speaking and in acting respectively. Thus, patients may be incomprehensible in their speech and yet be capable of performing work coordinately even when this requires a certain degree of reflection. Some cases may present the reverse, however.

This disturbance of association can also be observed when the patient is asked to name the first word that suggests itself to him on hearing a word pronounced by the examiner. Then, again, these patients may present a comprehensible connection of ideas, but their association is such that it is difficult to see any connection between them and the word spoken by the examiner. This manifestation does not appear in any other form of insanity. Thus, for instance, the word *swim* suggests the word *authority*; the word *cat* suggests the word *fir-cone*. In these examples there does not seem to exist any link between the ideas. In other instances, the patient may use, if not quite disconnected, most peculiar and unusual words. Thus, the word *fidelity* suggests the word *union*, *head* suggests *shoe, tree,—nature's product* and *walk,—going away*. It is evident that in cases slightly affected these signs may not be found during a test of some two hundred words,—which I generally use for diagnostic purposes. In the majority of asylum cases, however, about one hundred test words are sufficient to show the presence of the disturbance.

In their *behavior*, these patients have the following well known characteristic traits: their acts are not based on motives, but on chance fancies. When they tear their clothes or break window panes they cannot give any reasons for their actions or else the reasons are improvised and quite incomprehensible. As the remainder of the disturbances of association are quite familiar to the reader, I shall not stop to consider them here and to remind that these changes are not met with in any other psychic affections.

Another characteristic of dementia præcox is an *unimpaired memory*. This statement is to be taken *cum grano salis*. When the association of ideas is greatly hindered, it is evident that images are, for the time being, revived with difficulty; but as soon

as there is an improvement in the progression of ideas, the intactness of the memory becomes evident. When such patients have not used their minds for many years, they forget part of their knowledge, but probably not more or even less than does a sane person, who has not exercised his mind on given things for a long time: Memory cannot register events in confusional hallucinatory states, as is evidenced by the fact that sane persons forget most of their dreams.

Orientation in surroundings is retained, although it may become impaired through the effect of intercurrent hallucinations. In other psychoses,—as those of organic origin,—memory and power of orientation are primarily disturbed,—that is to say,—the symptom is caused by the disease itself, but not by intercurrent and accidental disturbances.

The *perceptive faculty* in dementia præcox remains good so long as it is not impaired by the patient's indifference. The patients register mentally everything that is within their psychic comprehension and can with ease relate what is going on about them if they are in a suitable mood.

In this disease, as in all other mental diseases, there may be found a variety of psychic symptoms, such as hallucinations, delusions, maniacal and melancholic excitement, etc. The clinician can always separate, however, the fundamental characteristics of the disease from the accidental symptomatic accompaniments.

Serbski further says that the single, so called katatonic symptoms, are not characteristic of the disease in question. Certainly not, if they are considered independently. Catalepsy, for instance, is found in the epileptic; but in these cases it is generally connected with disturbed consciousness. The same is true of the sign called negativism. In the epileptic, however, the latter is the result of other conditions: it is secondary, caused by delusional ideas or by epileptic emotional states. Stereotypia may be met with in the melancholic, for instance, but this is caused by continuous emotions that need the same expression. In dementia præcox, on the contrary, stereotypias, such as verbigeration, etc., are some of the primary manifestations of the disease, the detailed consideration of which I omit here.

The “*mannerisms*” of dementia præcox are not met with as constant accompaniments in any other psychic affection. Among the symptoms of dementia præcox, which may be wanting in some forms of the disease, are anomalies of the pupils, of the vaso-motor tone and of the secretions. The first can easily be differentiated from those found in general paralysis.

As regards the sub-groups, we find no distinct boundaries be-

tween them. The hebephrenia of to-day may become a katatonia to-morrow and the latter form may figure as a typical paranoidal form a few days later. In a word, there does not exist any definite line of demarkation between the different varieties of the disease. The disease as a whole, however, is well differentiated from other forms of psychoses.

I must admit that in practice it is not always easy to differentiate the disease from paranoia. I suppose that there are certain forms of psychoses that belong neither to dementia præcox nor to Kraepelin's paranoia, but which, symptomatologically, present resemblances to both diseases. It must further be remarked that there are cases of dementia præcox that present only the above named cardinal symptoms,—disturbances of association and of emotions,—without ever being accompanied by katatonic symptoms, excitation, delusional ideas, hallucinations, etc. Such cases are not rare outside the asylum walls.

Some of Serbski's less important objections are easily answered. It is enough to point out one of them. According to him, dementia is not always an accompaniment of the disease, nor is the disease always *præcox*. To be sure, the name is not well chosen; but the question is only that of a *nomen et flatus vocis* and not of the thing. To waste words about it is, therefore, useless.

It is true that the disease has no definite *pathology*. Is this any reason why its existence should be denied? There are still many nervous affections, the pathology of which remains unknown.

SUMMARY. Dementia præcox is characterized by a definite kind of mental enfeeblement that is not found in any other psychic disease. The emotions, as well as the association of ideas, are attacked. There exists no line of demarkation between the various forms of the disease. This is true of any individual case as well as of the disease in general. The disease is easily differentiated, however, from other psychoses, although some ill defined paranoidal forms may make exception to the rule.

CLINICAL FACTS IN THEIR RELATION TO ANATOMO-PATHOGENETIC FINDINGS.

By

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Giacomini was the first physician to point out the existence of two major varieties of microcephaly. According to him, the essential form of microcephaly was due to an anomalous cerebral development, while the other major form was either caused by accidental pathological processes or was accompanied by them. Thus, he introduced the notion of the dual pathogenetic form of idiocy, and many authors soon supported his views by clinical illustrations of this dual form.

Tomaschewsky enlarged the above mentioned conception of idiocy. Indeed, according to him it was possible to find a respective relation between the pathogenesis and the symptomatic manifestations of the various idiocies. Brissaud, Freud and Koenig also contributed largely to the study of cerebral diseases in children. Ireland, Shuttleworth and Beach have contributed to the psychiatric study of the same question. Finally, Tanzi has made the most valuable researches in the two pathogenetic types of idiocy.

De Sanctis speaks with some reserve about the differential characteristics of the two forms of idiocy, but he recognizes the utility of such a distinction from the medico-pedagogic standpoint. With this end in view, and for the purpose of arriving at an adequate diagnosis in the various cases, he delved into the study of the pathogenetic nature of the phrenasthenia and separated it from the cerebropathic forms (cerebroplegia of Frued and Tanzi) of pathological origin, from the biopathic forms, or genetic, or evolutional forms (common idiocy of Tanzi) and from the cerebro-biopathic forms (according to the definition of Giacomini of combined microcephaly), which are of double origin, caused not only by evolutional pathogenesis, but also by ordinary pathological factors.

In 1900, I made a careful study of the idiocies in their relation to their pathogenesis as well as to their anatomo-pathology, and gave an outline of the classification of these diseases according to the determining causes. In my publications on this subject at the date above mentioned I tried to coordinate my views with those of Sollier, Freud and Tanzi regarding the correspondence of clinical symptoms to anatomical lesions. I conducted my investigations most carefully at the Medico-Pedagogic Institute for Idiots at Turin and I found that my views on this subject were not quite identical with those of the authors cited above. Indeed, I found that the correlation of the symptoms and the pathogenesis of the idiocies is far from being well defined and constant, as some authors claim it to be.

The clinical observations relating to this question are quite numerous, but the corresponding anatomical defects found are not always clear and explicit. It seems to me, therefore, that for the present it would be wise to renounce the theory, seductive as it may appear, of constant correlation of clinical manifestations of the various idiocies and their respective cerebral lesions.

Sollier, for instance, affirms that all idiots present cerebral lesions, while imbeciles are free from such lesions. As for Koenig's opinion in this matter, the idiocies are to be considered as being so many psychic cerebroplegias. This opinion is due to the fact that excessive importance is attached to the most insignificant motor disturbances that are frequently met with in these diseases. In this manner one is led on to believe that at the root of the psychic disturbances lies the same cause as that which brings about the motor impairment; in other words, it is thought that idiocy and cerebroplegia are due to one and the same cause.

Freud and Ganghofner admit the existence, however rare, of pure degenerative or common idiocy; but they are absolutely peremptory when claiming that all idiots who present motor symptoms should be classed as pathological or cerebroplegic cases and that the common idiots are only those few who are free from motor signs.

Tanzi masterfully outlines the two fundamental clinical forms of the idiocies and gives a fine analysis of their respective psychiatric traits. He seems to be influenced by Sollier and Freud, however, when he asserts that common idiocy and imbecility are not generally characterized by heredity, epileptiform convulsions, paralysis or by contractures.

I shall not stop to consider here the above ideas of Sollier. There may exist a certain correspondence between this theory and the respective facts. In order to simplify the under-

standing of this matter it is well to know that the word "lesion," as used by Sollier, does not relate to pathological alterations in the strict sense of the word (in the sense that it is used by other authors here cited); and then, it is well to know that, as a rule, the severer forms of idiocy correspond to grave cerebral alterations; these alterations may be either the results of arrested cerebral development, or relictus of inflammatory pathological processes or else of a combination of both preceding conditions. The second part of Sollier's assertion, however, cannot be accepted quite as freely. For, as is well known, there are numerous cases of imbecility, of a more or less grave nature, accompanied by cerebral lesions that may be even profound and yet may be considered as being due to evolutional or pathological conditions or to a combination of both. We should recall the fact that there are numerous cases of microcephaly, of hypertrophic sclerosis, of absence of the corpus callosum and of other cerebral defects of evolutional nature, which are not accompanied by grave idiocy. There are numerous cases on record of porencephalus, of the pseudo or true variety, accompanied by extensive cerebral lesions and sometimes by microgyria, but which show comparatively slight intellectual defects; finally, there are infinite clinical varieties of psychic cerebroplegia, of a more or less grave nature, consequent on meningitis or meningo-encephalitis.

Just as there is a lack of correspondence between Sollier's assertions and the anatomical facts, so is there an incongruity between the psychic characteristics and the corresponding educability of the subjects as given by him. There seems to exist a divergence between the terms used by Sollier and those used by other authors. It seems that the essential nature of idiocy as given by Sollier is identical with that of imbecility as defined by him. His terminology seems to differ from that of other authors, from that of Tanzi, for instance. In substance, however, the psychic definitions given by the two authors seem to correspond in a broad meaning.

Tanzi has to his credit the fact that he bases his pathogenetic definitions on modern pathology, while Sollier bases his classification on the degree of psychic impairment. While these two psychiatrists use a different terminology, they both lead up to the same fact; and does not this fact show that it is difficult and almost impossible to draw a line of demarkation between the psychic traits of the two fundamental types of idiocy here considered?

A corresponding difficulty arises from the standpoint of the educability of these subjects. According to Sollier, the two types, the imbecile and the idiot, with their respective pathology (degenerative and concrete pathological lesion), become extra-social or

educable and anti-social or ineducable. It is evident that Sollier is guided in his argument simply by the degree of psychic disturbance rather than by its nature.

One of the points upon which Freud and Ganghofner, and to a certain degree Tanzi, insist, is the absence of neuropathic heredity in cases with cerebroplegia, and its presence to a marked degree in cases of common idiocy.

Treating of this subject, I demonstrated that in the forms of idiocy of pathological origin, heredity may be present or absent in an equal proportion of cases. I came to these conclusions by personal clinical researches. I may add that this heredity seemed to be less marked in cases accompanied by paralytic symptoms.

Recently, de Sanctis made some investigations on the subject in the Medico-Pedagogic Institute of Rome and came to the conclusion that both types here considered belonged to families which were degenerate both psychically and physically. His figures show that this heredity is one fifth less in the cerebroplegic cases than it is in the common idiocies.

From the study of some forty children at the Medico-Pedagogic Institute of Turin I obtained results similar to those of de Sanctis. It is not always easy to determine which of the heredities, neuropsychopathic or not, is most fatal in its workings; but it may be said that in the common pathological idiocies heredity is generally less marked. In the degenerative forms, on the contrary, heredity is more grave, more direct and in addition one finds there histories of alcoholism, moral insanity and epilepsy.

From the standpoint of the education of these subjects it is important to define the correlation of given heredities to the diseases here considered and to the motor manifestations which accompany them. There seems to exist a certain basis for the tendency of some authors to gradually restrict the limits of common idiocy and to enlarge those of the cerebroplegic variety. The argument in favor of these limitations is the following: Every motor disturbance must be caused by a pathological process. And just as a pathological process may be localized in a purely motor region, so it may affect a purely psychic area; in the later case, the idiocy is not accompanied by motor symptoms, but is essentially a true psychic cerebroplegia. Indeed, one quite frequently finds cases of aplegic idiocy as a result of post-natal meningitis. The above mentioned authors do not mention the reverse facts, however, that is, that an arrest of psychic development, as well as an anomaly of development, may affect the cerebrum in its purely psychic function, but may also be manifested by an impaired motor function exclusively or combined with a psychic derangement.

In July, 1900, I published an article in the *Archivio di Psichiatria* of Lombroso, in which I demonstrated that there were cases of biopathic idiocy in which the idiocy was the initial and fundamental manifestation, and epilepsy was a secondary development. It need hardly be explained that such an epilepsy comes under the heading of motor symptoms. It must be admitted that essential epilepsy, under the circumstances above described, is not always easily differentiated from symptomatic epilepsy, unless one has accurate data regarding the onset and the development of the acute pathological or the traumatic processes. There are congenital cases in which the diagnosis of the convulsive form is difficult even in the face of the clinical facts and histories they furnish; spasms, pareses and contractions, in such cases, may gradually become transformed into epilepsy, the nature of which cannot be determined until a post-mortem examination can be made.

In my article above mentioned I pointed out the fact that essential epilepsy was a frequent accompaniment of idiocy of evolutional origin. I enlarged my views on this subject, however, after having made a thorough analysis of my own cases due to hypertrophic cerebral sclerosis and of those of other authors, which were accompanied by various motor disturbances believed to be of cerebropathic nature, such as pareses, muscular contractures, hemispasms, etc. I need hardly repeat that idiocy due to hypertrophic sclerosis is of evolutional nature. Cavazzani confirmed my assertions by his own studies of this form of idiocy.

Mya and Levi, Donaggio and Finizio demonstrated, before as well as after the publication of my studies, that spastic diplegia, general contractures (syndrome of Little) could be considered as being due to arrest of development. As for amaurotic idiocy with general or partial contractures, it has been recognized, since the publication of my studies, as belonging to the degenerative type.

I shall not enter here into any consideration of porencephalus and of microgyria. As for true microcephaly, it is often accompanied by epilepsy.

Such cases have been recorded by Giacomini, Scarpatetti and others, whose names escape me. Almost all cases of this kind worthy of consideration are collected in the memoirs of Mattrell and Meine.

Treating of amaurotic idiocy, B. Sachs stated in an article, which was published in 1896, that paralysis which accompanies this disease may be either of flaccid or of spastic nature. Interesting contributions relating to this question were also published by Tay-Sachs, Tay, Kingdon, Castor, Magnus, Wadsworth, Goldzieher, Hirschberg, Starr and others.

It is intimated (Sachs-Kingdon) that in these cases one should not incriminate pathological processes as being the causes of the motor disturbances. Microscopic investigation shows that no traces can be found of recent inflammatory conditions or of vascular changes in the meninges; there is also an absence of neuroglia cell proliferation. The condition here is one of pure agenesis of the cerebral cortex. Thus, one finds insufficient differentiation of the cerebral zones, a large number of embryonic cells and anomalies of pyramidal disposition. These facts were verified by many other investigators, among whom may be mentioned Falkenheim, Frey, Clairbonne, Hirsch, Kuh, Higier and Patrick. Russel and Peterson are among the newer men whose microscopic researches confirmed the statement in question.

Observation of individual cases shows that this form of idiocy may be accompanied either by flaccid or spastic paralysis, by total or partial pareses, or by contractures of a similar nature on one or both sides of the body.

The variance of statistical data of different authors with reference to heredity is probably due to the fact that different pathological forms are brought under the heading of the syndrome of Little.

According to Fuchs, only six out of forty-nine cases, are free from neuro-psychopathic heredity. Freud and Ganghofner found, on the contrary, that from thirty-four to thirty-five per cent. of the cases have no such heredity.

The syndrome of Little is generally understood to be an infantile spastic cerebral diplegia accompanied by an arrest of psychic development. Marie, Brissaud and van Gehuchten seem to define Little's disease somewhat concretely as follows: an infantile cerebral diplegia, properly speaking, with spinal spastic rigidity in the prematurely born. According to these authors, only cases which correspond to this definition can be brought under the heading of Little's disease; they explain that under these circumstances only can it be said that the disturbance is caused by a true arrest of development of the pyramidal tracts in the spinal cord. However, recent microscopic investigations by Mya, Levi, Donaggio and Finizio have led up to somewhat different conclusions. It appears, from these investigations, that children born at full term may present a typical spastic cerebral diplegia, caused by pathological processes that are followed by a true arrest of development of the cerebral cortex.

Thus, there exists another form of idiocy, which is quite commonly met with, and the fundamental character of which consists of motor symptoms called spastic rigidity; and this form of the dis-

ease may be considered as being due to a simple arrest of development. Under these circumstances, the idiocy may be said to come under the heading of common idiocy, although one thus risks being inaccurate in the definition.

I shall now consider idiocy due to hypertrophic sclerosis properly speaking. In this form of the disease, essential epilepsy is the most important of the motor symptoms, although it may be accompanied by many other motor disturbances. In my study of tuberous sclerosis, published elsewhere, I considered at length the various motor disturbances met with in this disease. I shall relate here concisely the salient features brought out in connection with these disturbances.

The onset of essential epilepsy is in many cases preceded by localized convulsive manifestations of tonic or of clonic nature (Bourneville, Brissaud, Boumaire, Pollak, Schuele, Berdez, Sailer, Pellizzi and others); sometimes these attacks appear rarely at first and become more frequent and complete later on (Brueckner, Pellizzi). Pareses and grave spastic contractures may be observed (Bourneville, Berdez); slight pareses or contractures and strabismus are rather common (Bourneville, Brueckner, Pollak, Pellizzi); finally, there may be found hemipareses (Popoff), limited and diffuse movements (Brueckner, Pellizzi).

Breuckner, Koster, Cesaris-Demel and Cavazzani suspected, and I myself have demonstrated, that idiocy due to cerebral hypertrophic sclerosis has a particular pathogenesis and is caused by developmental defects.

There also exists a number of idiocies of biopathic nature accompanied by various impairments of the motor functions to a more or less marked degree, which, according to the precepts of Koenig, Freud and Tanzi, should be taken for cerebroplegias of pathological nature.

The question may be asked whether aplasia, agenesis and cerebral hypertrophy are totally independent of pathological factors. This question should be dwelt upon as much as possible. It may be said, in answer, that if one could trace the defective development to its very beginning, a pathological element would be found which first started the defective development. As the subject is a delicate one, however, I shall not enter into any detailed argumentation regarding it. In order to argue in favor of a pathological element as above intimated, one would have to distinctly point out some pathological signs that could be regarded as forerunners of congenital defects. If these forerunners existed in the cases in question they would be of various natures. One would find here signs of old inflammatory processes, with opacities in the meninges

and vascular changes, followed either by cerebral destruction or by atrophy, etc. All these signs are absent, however, in the cases in question.

Finally, the neuroglia proliferation is to be considered. This proliferation in itself, accompanied by developments above indicated, has no particular value in support of the pathological theory. First of all, the neuroglia may, by reason of its histogenetic defect, present an exaggerated proliferation process. Then, there can be no doubt that in the cerebral aplasias, in the cortical agenesis and eterotopias, in which embryonic cells persist and where there are nervous elements, which are inadequate for their function either by their structure or disposition, one finds a prevalence of neuroglia proliferation of the specific elements. Even under these conditions, the brain may present, in the long run, a normal consistency; only in old age may this aspect simulate that of atrophic sclerosis due to polyencephalitis. The latter change is caused by the process of involution of the proliferated neuroglia itself.

There can be no doubt, then, that cortical defects of congenital nature in the motor regions may give rise to epilepsy in its various forms of manifestation. These defects may be the causes of pareses, spasms, mono- or paraplegias, choreic movements, etc. The point of particular interest is the fact that all these motor disturbances may be caused either by the congenital defects themselves, or else by the involution process in the nervous elements, which are not capable of development and which become surrounded by neuroglia proliferation.

Psychic defects.—These have been well described by Tanzi. The idiot called here "common idiot" presents perversion of character; in the cerebroplegiac the latter is insufficient. Psychopathic episodes, expressed by delusions, etc., met with in the types of the degenerate, are absent in the common idiocies. I insist, therefore, on the fact that an arrest of psychic development, accompanied by these disturbances, should come under the heading of imbecility as grouped by Schuele. I repeat that one should be reserved as to what constitutes idiocy of the essential type. As for the idiocies frequently met with,—they are, as a rule, associated with neuro-psychopathic heredity. One commonly finds in these cases, therefore, all degrees of disturbed psychic function.

The course of the disease is not always typical. It may be sudden in onset, as it is in the pathological forms. Sometimes it may be similar to that found in sub-acute meningo-encephalitis. Slight febrile movements of short duration may appear at more or less long intervals. It may be accepted, therefore, that the congenital forms are due to prenatal pathological processes. On the other

hand, many cases of Little's disease, of amaurotic idiocy and hypertrophic sclerosis, have been known to develop quite suddenly and to quickly manifest all the characteristic symptoms.

The duration and termination vary with the cases. In grave cases, the course is of short duration, regardless of the nature of the pathogenesis. The course is of long duration in slight infantile cerebroplegia.

From what precedes, it is seen that it is not always easy to determine whether the disease is of prenatal or of postnatal date, and to diagnose the pathogenetic from the symptomatic forms. Another difficulty arises from a fusion of pathogenetic causes of developmental and pathological idiocies. Many authors have studied the relation between developmental defects and pathological processes. Giacomini was the first among them, however, to have pointed out that microcephaly was a true developmental disease, the clinical symptoms of which could be accompanied by results of pathological processes. His description of the disease was followed by others treating of various combined cases of microcephaly and developmental defects. I myself stood in line with those who claimed that the association of anthropological defects with those caused by pathological processes was possible. Thus, spurious cases of microcephaly were pointed out, which had their origin in an initial pathological lesion that was subsequently followed by defects of development. The interest attached to such cases is the fact that they do not represent the variety of the disease due to primary degeneration. It is evident, from these statements, that it is not only difficult, but even impossible, to draw a line of demarcation between these varieties of the disease, unless there exist absolute data by which one can be guided.

There can be no doubt that development defects and pathological results are frequently associated. It is difficult to indicate, however, where the former ends and the latter begins. One often runs up against these facts in microgyral and in porencephalic cases. If a pathological process gives the first impetus to the formation of congenital defects, this process is not easy of detection after birth by the means at our disposal to-day.

To conclude, what deductions is one to make from what has been said with reference to pedagogic purposes? It is evident that is it impossible to give positive indications on this subject. One can only say that neuro-psychopathic heredity is eminently present in most of the cases. In my own psycho-pedagogic practice, I am not guided by the various pathological origins of the diseases. The individual capability of the patients is taken as the preferable guide. In a way, it may be said that I am guided by the same

principle that Sollier follows in the direction of the education of the subjects in question.

Conclusions: 1. Given a case of congenital idiocy which becomes apparent during early infancy and which does not present any acute manifestations, it is impossible to make a positive diagnosis regarding the true origin of the affection on the basis of clinical facts.

2. The idea, introduced by Koenig and Freud, calling for the restriction, on clinical principles, of the limits of the so-called common idiocy (degenerative, genetic, evolutive, biopathic) is erroneous.

3. Neuropsychopathic heredity is generally found in cases of cerebroplegias.

4. The duration depends on the nature and the gravity of the lesions. The educability of these subjects also stands in relation to these conditions.

5. The dual forms of the idiocies as considered above must be taken broadly: It may be that developmental defects have their primary origin in pathological processes of the various cerebral zones; besides, the former may manifest themselves in a manner quite similar to that characteristic of pathological idiocies, as has been demonstrated in this paper.

A CASE OF EROTIC DELIRIUM OF SYSTEMATIC DEVELOPMENT.

OBSESSION OF SCRUPLES WITH PSEUDO-HALLUCINATIONS.—A CONTRIBUTION TO THE STUDY OF THE DELIRIUM OF SCRUPLES.

By H. PIÉRON, *Preparateur, School of Higher Studies, Villejuif.*

It is now a recognized fact that there exists an intimate relation between the various obsessions. Obsessions of scruples hold an important place among the various other obsessions. Thus, to-day, there are few children who are not subject to some form or other of obsessional scruples. Some children have a mania to touch certain trees when passing them, others feel compelled to walk on certain stones of the pavement, etc. As a general rule, the importance attached to these peculiarities is proportionate to the intensity of the obsession. At times, however, these obsessions pass unobserved; and obsessional scruples are quite apt to be overlooked on account of the frequency of their existence in young children. There are instances where obsessional scruples are difficult of recognition, particularly when they are polymorphous in nature. There is generally an additional difficulty in the matter of recognizing these obsessions: subjects afflicted with obsessional scruples generally try to hide their morbid weakness.

The question of impulses has been treated of by many authors. The latest on this subject is that by Pitres and Régis.* The present communication is only a modest contribution to the study of obsessional scruples, as illustrated by the case below cited.

E. X., thirty years of age, domestic. She was born of peasant parents and is said to have had a normal childhood. She played with children of her own age and always sought their company. At school, she did not make much progress and left it after she had acquired some rudimentary education. As she liked farm life, she was placed as a shepherdess when she was seventeen years of age. One day, some misadventure befell one of her sheep and in consequence the patient was morbidly worried about the matter; she was constantly accusing herself of being responsible for the mishap to the sheep. She was then placed as general house-worker; she soon forsook her place, however, because she was jealous of another servant, whom her mistress preferred to her, she imagined. She changed from place to place several times, either for reason of jealousy or for the purpose of being better paid, and finally she placed herself with her present employer, for whom she has been working for the last seven years.

*Pitres and Régis, *Les Obsessions et les Impulsions*, 1902, Octave Doin, Paris.

MENTAL DISTURBANCES.—The most salient features of her mental disturbances developed themselves while she was working for her present employer. The house in which she worked was situated opposite a printing establishment, and when stationed at any of the windows of the house she could easily see the printers. Among these printers she noticed that one was tall and fair and another was short and dark complexioned. These two workmen preoccupied her mind considerably and they became the subjects of her delirium; the construction of the latter is most interesting from the standpoint of its evolution.

She imagined that the printers in question looked at her whenever she found herself at one of the windows of the house and that both of them were in love with her. As neither of them declared his love for her, she concluded that they were both exceedingly timid and did not have the courage to make a verbal declaration of their sentiments. Considering this difficulty, she was quite happy in having their love at a distance. She often spoke of this situation with an air of certainty, although there was nothing real in this matter. The love affair was the product of her own imagination. The development of this delirium soon became so marked that her whole mind seemed to be taken up with the subject of the imaginary love affair. Everything she saw or heard she immediately connected with her morbid ideas. Thus, one day, she met in the street an elderly and respectable looking couple and she immediately concluded that they were the parents of one of the printers, who were going to see her about making arrangements for a marriage engagement between their son and herself. As this thought came to her, she suddenly became very bashful and ran into the house to hide herself. One of her cousins, who saw that she was acting under the influence of delusional ideas, tried to make her understand her faulty position, but without success. He then purposely informed her that both printers were married men. Instead of convincing her he only helped to increase the ardor of her affections: she said that the news was given her as a test in order to find out the strength of her devotion. Discouraged by this optimistic construction on the part of the patient, her cousin told her that he had heard that the printers were "tired of her." This information affected her and she became considerably depressed. This mental depression was soon followed by a true delirium of obsessional scruples. The first marked manifestation of these obsessions took place after the following incident: She received news that her father was dangerously ill and she was asked to hasten to his bed-side. She replied that her friends who conveyed to her this news and request

were her enemies, who wished to see her leave her place of employment as well as to put a distance between her beloved printers and herself. She considered this a barbarous method of showing one's friendly concern. As this message was followed by an urgent request that she hasten to her father's death-bed, however, she finally consented to leave the house of her employer. Her father died three days after her arrival.

She then manifested a series of self-accusations. She said that she was responsible for the death of her father. She explained that her immoderate conduct regarding the printers had an influence "at a distance" and caused the death of her father. She was guilty of many faulty traits of conduct, she said: she talked too much, she did not devote enough time to going to church and she was a "bad subject" in general. As she did not see the printers, she imagined that they had left the city and had gone down to the Transvaal Republic in order to get themselves killed in the war there and thus "drown their grief" because they had no way of seeing her. She then bewailed her fate for being the direct cause of an impending death of these printers. In fact, she was a murderer, she said, as the printers were certain to meet their deaths. She even imagined that when she was seen in the street, people pointed at her with their fingers, looked at her with horror and said "there goes the murderer" She felt that she was liable, at any moment, to be arrested.

At this point, the delirium of the patient became interposed by a series of doubts: Everything she saw or heard she accepted with doubts of a scrupulous nature. She also interposed these doubts with questions regarding her culpability. Thus, she asked whether she was not the cause of the death of her father and of the printers, of the loss of some cloths which had disappeared from the house; she worried about having imparted to a friend some confidence entrusted her by her mother. She asked whether it was not a grave misdemeanor on her part to have betrayed a confidence entrusted her when she was a child.

All these questions were not only asked in a delusional manner but they were also answered in an equal way. Thus, every one of her questions was answered by obsessional visions of certain colors; when her question was followed by a vision of red she interpreted it as meaning that she was a criminal and that she would kill herself. When, on the contrary, she saw a green color she felt that there was hope for her in the future; she also interpreted the meaning of this color as an indication that she was to marry one of the printers. The obsessional vision of yellow, however, signified that her beloved printers were untrue to her. She had no

color hallucinations, but there were days when she directed all her attention to given colors, remaining unimpressible to all other colors; some days, she saw green only, at others, red was the color which monopolized her color perception, at others, again, yellow was the color which dominated her mood. In her own words she expressed the situation by saying that she "saw red" or that she "saw green," or that she "saw yellow."

Before she was brought to the asylum she "saw red"; she was certain that she was guilty of many criminal acts, according to the interpretation which she gave to the persistent vision of the red color. She, therefore, had a continuous desire to kill herself.

This case presents a peculiar clinical development. The patient has always led a life of isolation, either on the farm or in the kitchen of her last employer, leading an unmarried life. In this condition of isolation she first constructed a romance in reference to the printers whom she noticed working in a building situated across the way from the house in which she was busy with her housework. In her case, this romantic construction was the pivot of a delirium that is not only complex, but also evolutional in nature, as was shown above. At first, there was only an obsessional taint in her ideas; then the obsessions intermingled with delusions, and an erotic delirium soon followed. Two moral shocks followed this delirium and the latter was converted into a delirium of scruples, accompanied by anxiety and worry. Thus, the delirium appears now as an erotic delirium with obsessional scruples and with ideas of culpability. This delirium is followed by a peculiar tendency to question everything about her and by a still more peculiar manner of answering her own questions by obsessional perceptions of certain colors—each color representing a given answer.

I do not recall having found in literature a case similar to the one above cited in reference to the obsessional vision of colors in the manner described. From a psychological standpoint, much interest attaches to the gradual development of the obsessions, the delirium and the delusional interpretation of the obsessional perception of colors. Thus, the criminals use the expression "to see red." In the vocabulary of this class of subjects, the red color has a bearing on the commission of crime because the said color is that of blood. In the case of the patient above described, the same color signifies crime, guilt, misfortune, etc. Thus, there seems to exist an identity of mechanism in the formation of ideas which are totally different in form. The psychiatrist is, therefore, called upon to thoroughly analyze the relation between the psychic mechanism and its corresponding psychiatric manifestations.

NERVOUS LESIONS IN AMYOTROPHIA OF ARTICULAR ORIGIN.*

By DOCTOR GIACOMO PIGHINI.

Daily observation has demonstrated that muscular-atrophy is a frequent consequence of acute or chronic articular inflammatory processes. This subject has been known to the classic authors, but in our own day Vulpian and Charcot gave a particular impetus to the study of this question.

According to Vulpian's theory, which was later developed by Charcot, amyotrophia of articular origin was due to a special trophic trouble of the muscles, which depended on dynamic disturbances of the anterior spinal horns. The trouble made itself felt in the muscles through reflex avenues. Thus, it was explained that the pathological articular sensibility was registered in the posterior horns, then reached the anterior horns; at this point the motor cells underwent some special modification under the influence of which the muscular atrophy took place.

The architectural explanation of this theory was supported by experimental demonstration. Indeed, Deroche, Raymond and Hoffa fully demonstrated the value of the theory. Thus, they found that artificial arthritis in dogs was followed by amyotrophy some days after the lesion was inflicted. This atrophic muscular process could be stopped, however, by severing the continuity of the reflex avenue. This experiment fully demonstrated that the motor disturbances depended on alterations of the sensoro-motor reflexes.

*Simultaneous publication in the *Rivista Sperimentale di Freniatria*.

Besides the explanation above cited there were still others, and one of them was that given by Brown-Séquard. According to his view, the morbid process was explained on the ground of vaso-motor disturbances. Instead, then of calling the disturbance *sensoro-motor* he called it *sensoro-vaso-motor*. The explanation in favor of this theory was as follows: The regions in the posterior roots destined to control vascular action were affected by the morbid impressions received from the sick joints; the disturbed circulation that followed brought about impaired nutritive conditions in the joints and the muscular reaction was manifested by atrophy.

I shall make only a cursory review of the other theories which are obsolete to-day, because they have been disproved by clinical observation as well as by experiments. The theory of inanition was upheld by Cruvelhier, Richer and Max Sultzer; this theory was proven to be erroneous, because the prompt onset of the atrophy did not justify the hypothesis. Indeed, in experimental arthritis, atrophy may set in within the course of a few days.

Still another theory that lived to be discarded was that which explained the phenomenon of the atrophy on mechanical principles. The advocates of this theory said that the pressure produced by the inflammatory products in the joints caused the atrophy of the muscles. The fallacy of this supposition was demonstrated by the fact that muscles that had no immediate connection with the affected joint were also found to be atrophied.

Later on still another theory was brought forth. It was supposed that ascending neutritis was the cause of the atrophy. Histological researches disproved this, however, as no true nerve degeneration was found in these cases; besides, the rapidity of the process of the atrophy could not be explained on the ground of this theory.

It remained to be found out, then, how an articular inflammation could cause muscular atrophy of such sudden development,—whether the pathological process took place through reflex action, and how this process was accomplished. The literature on this subject contains some microscopic observations of which some are negative in results. Duplay and Cazin (1) were among those who made these observations. Mignot and Mally investigated cases due to experimental arthrites, while Klippel and Folli respectively studied the atrophies in chronic arthrites. The results obtained by these authors seemed to be positive from a microscopic standpoint; the indicated alterations are not sufficiently clear, however, as regards the seat and the constancy of the histological lesion in the spinal cord. Mignot and Mally (2) made numerical examina-

tions of the cells in the anterior spinal horns and found that there was a diminution of these elements in the horns that corresponded to the affected joints. Folli found a distinct lesion in the spinal cord of a case of arthritis deformens. The lesion was confined to a group of cells situated ventrad in the anterior horn, near the white commissure (3).

Thus, it is seen that a scientific interpretation of the malady existed on theoretical and experimental grounds. Its pathology still required explanation, however. I have tried, therefore, to find this explanation through experimental work. In this modest contribution I submit the results obtained regarding the nature of the trophic changes here considered.

My experiments were made with regard to the anatomical changes found in the spinal cord during the course of amyotrophy of articular origin.

I examined every tissue that could functionally be connected with an affected joint. Thus, I examined the articular surfaces, the nerves, the corresponding spinal ganglia, the respective spinal enlargements and the atrophied muscles.

For my experiments I used adult rabbits that were in good physical condition. Chemical or infective agents were used and injected into the joints in which I wished to cause inflammation. The injection was made with a Pravas syringe. Thus, I obtained septic as well as aseptic arthritides. The septic variety was obtained by injecting one-half a cubic centimeter of a culture of staphylococcus pyogenus aureus; the aseptic inflammations were caused by intra-articular injections of a few drops of tincture of iodine, turpentine or of a ten per cent. solution of chloride of zinc. The most marked results were obtained in the joints injected with chemical substances, and turpentine causing the severest inflammations. Thus, an intra-articular injection of 1/5 c. c. of oil of turpentine was followed quickly by marked local tumefaction, hyperemia, peri-articular edema, contraction of the extensor muscles, and by pain. The animal kept the injured limb off the ground and atrophy soon set in in the affected extensor muscles. The first signs of atrophy showed themselves after the fourth or the fifth day; marked signs in the extensors could be seen after the first week that followed the intra-articular injection. The acute symptoms of the first few days gradually disappeared; the tumefaction was first to disappear, then followed an attenuation of the pain; both lasted altogether about a fortnight. The muscular contraction was followed by paresis, and the limb on the affected side could not be used at all or was dragged.

When an arthritis was once brought about, atrophy of the cor-

responding muscles invariably followed; besides, the extensor muscles were invariably the ones involved. The muscles affected were generally those above the injured point. Thus, an injection into the elbow joint was followed by atrophy of the triceps muscle, and that of the knee-joint was followed by atrophy of the quadriceps muscle as well as by that of the adductor muscles. In relation to the sound limbs, the atrophied ones lost in weight from $\frac{1}{5}$ and $\frac{1}{4}$ to $\frac{1}{3}$ of the total normal weight.

I also succeeded in obtaining similar results by intra-articular injections with the other substances mentioned above.

The results of the above mentioned experiments lead to the following conclusions:

The chemical, as well as the bacterial agents, if injected into the joints, may cause muscular atrophy.

The rapidity and the gravity of the developed amyotrophy depend on the irritative qualities of the pathogenetic agent.

The atrophy invariably affects the extensor muscles that are situated above the infected or inflamed joint.

The atrophy is preceded by contraction of the affected muscles and is accompanied or followed by paresis.

HISTOLOGICAL EXAMINATION.—I made a histological examination of the nerves, spinal ganglia, the spinal cord and the atrophied muscles.

THE NERVES.—As the knee was the chosen articulation for the experiments, I made examinations of the crural and sciatic nerves and of those which supplied the affected muscles. The nerves were treated with osmic acid and by Hermann's method. The dissociation of the elements was made in glycerine. The examination showed that no alterations existed in the healthy limb; in the affected limb, however, there was a numerical increase of the fine fibres. The myeline sheath was completely absent in some places and simply wasted in others. True degeneration was not found anywhere, but there was an impaired condition of the nerves that is generally called periaxile neuritis. At the level of the nodes of Ranvier, the myeline was wasted and even totally wanting in some places.

THE SPINAL GANGLIA.—The study of these ganglia was the special object of my work. So far as I know, they have not been studied in particular in relation to the pathology of articular affections here considered. They are important stations in the reflex path and consequently should be studied in connection with pathological reactions.

I follow the classification of the cells given by Cox (4) and

Lugaro (5). The cells are classed in four fundamental types and the lesions in each will be considered separately.

The four types are the following:

1. Large clear cells.
2. Medium clear cells.
3. Spindle cells.
4. Clear and opaque small cells.

I used Nissl's method, alkaline methylene blue (Cox) and hematoxyline (Delafield). As fixatives I used a saturated solution of equal parts of sublimate and picric acid; Mann's solution and Cox's III^d mixture. When treated with these substances the cells do not undergo any alterations or shrinking and show the finest changes in their chromatic substance.

I found no alterations in the small cells of type 4. The large clear and the spindle cells, on the contrary, showed changes of various degrees. These alterations ranged between simple deposits in the nucleus, to an ovoidal change of shape of the latter and complete deformity of the cellular body itself, accompanied by marked chromatolysis. There could also be seen complete cellular disintegration, with loss of its contour and raggedness of its outline. The nucleus was decidedly eccentric, of smaller than usual size, and the caryoplasma was uniformly colored.

The chromatic substance was gathered in lumps around the nucleus, especially near the centre of the cell, and was arranged concentrically. In some cells could be seen irregularly clustered granular masses. As a rule, normal cells were found among the disintegrated ones. These normal cells were always in the majority even in fields that contained the worst degree of cell disintegration. This applies to the cells of type 1.

Such was not the case with the spindle cells. The entire number of these cells is very small. Even in the normal ganglia they are seldom found in larger numbers than from 5 to 6 in a field. In the ganglia experimented on, the larger number of them were altered. The alterations are like those described by Cox and Lugaro, as they are found in lesions of peripheral nerves. These cells may also show various degrees of degeneration. I have not seen, however, any marked alterations of these cellular bodies.

In the spindle cells, the chromatolysis begins at the periphery and extends to the centre. The larger concentric disks become pale at first, then disappear, leaving a disfigured condition of the cell. The nucleus looks smaller than usual, is uniformly colored, and is studded with highly colored granulations. These soon become arranged in circumscribed masses, leaving spaces of protoplasm between them; this gives the protoplasm a vacuolated ap-

pearance. Such marked alterations may be observed some twenty days after the beginning of the lesion.

The cells of type No. 2 did not seem to me to be altered.

THE SPINAL CORD.—Examination under low magnifying power: The first peculiarity that attracts attention in the spinal enlargement is the unequal size of the diameters of the two anterior horns. The horn corresponding to the affected joint is the smaller of the two; the decrease in size seems to depend entirely on a shortening of the basal diameter,—that extending from the middle of the anterior commissure to the external limit of the lateral horn.

The groups of cells examined were the antero-median, the antero-lateral and the postero-lateral. There seemed to be no difference in the number of cells in the respective groups. There was a noticeable diminution in the number of cells, however, in the wasted horn. The decrease was particularly noticeable along its internal limits, near the white commissure, in the place where it corresponds to the posterior horn, and in the lateral horn. In some instances there was a numerical diminution of cells in some groups of Clark's column, on the affected side. The diminution of the length of the diametre was due, therefore, to the numerical decrease of the cells disposed along this axis.

EXAMINATION OF THE CELLS.—Nissl's method was used. Under a high magnifying power, the groups of the motor cells showed no appreciable changes in either of the horns. There were marked alterations, however, in the cells of the groups which presented a numerical decrease. Many of the spindle shaped cells became globular in form; some of these cells presented simply a nucleus surrounded by a little protoplasm; in some cases the latter was simply irregularly attached to the margin of the nucleus.

In some instances the cells were irreconizable or were reduced to a simple nucleus. In some of the larger cells the chromatic substance aggregated irregularly and gave the cell a vacuolated appearance; the cell then looked as if it had undergone a vacuolated degeneration.

The central canal was enlarged and the perivascular spaces were dilated. At times this enlargement was most noticeable, particularly in the central groups and along the internal margin of the anterior horn.

There seems to be an anatomical as well as a physiological explanation of these findings. We have seen that the motor cells which have direct control over the muscle nerve supply did not

show any alterations whatsoever. The groups of smaller cells, on the contrary, were affected. These cells have a special function. It has been pointed out by recent experimentors that they are trophic cells of the vaso-motor nerves. Gaskell, Mott and Biedl were the first authors who localized the vaso-motor centres in the spinal cord. More recently their discoveries were confirmed by the studies of Hoeben, Huet, Nottebom, Trouchkofsky, Lapinsky and Cassirer and by Scaffidi. The most complete as well as exact studies on this subject seem to be those of Onuf and Collins, who have made numerous experiments and have pointed out some important physiological corollaries (6).

According to these authors, the spinal centres of the efferent fibres of the sympathetic nerve are the following: 1, the paracentral group of cells; 2, the small cells of the lateral horn and 3, the small cells of the intermediary zone.

They call the paracentral group that which is situated on either side of the central canal and directly ventrad to the column of Clarke. The intermediary zone is that situated at the base of the anterior as well as of the posterior horns.

I found that in the cases here considered the lesions were confined to the cells or to those groups of cells which, according to Onuf and Collins, are the spinal centres of the sympathetic nerve. This applied especially to the paracentral group of cells. As is well known, it is agreed by all authors who have studied this question that this group presides over the sympathetic nerve. These cells invariably presented some lesions in my cases here described.

I think I am justified in concluding that in my cases the acute articular affection was invariably followed by pathological manifestations in the lumbar enlargement of the spinal cord on the side corresponding to the affected joint; this lesion was confined to the reflex tracts and centres of the sympathetic nerve.

THE MUSCLES.—All the fibres of the affected muscle were diminished in size and discolored, and the transverse striae were impaired or wanting. The nuclei of the sarcolemma were increased in number and arranged without any order in relation to the fibre. The perimesium was slightly hypertrophied. The vascular walls seemed to be normal and the vessels were empty.

Thus, the microscopic examination shows that there is an invariable lesion that affects well defined groups of cells.

THE ARTICULAR CAVITY.—The articular cavity is the seat of an inflammatory and destructive process. The fine nerve endings in that cavity are directly affected by the inflammation and their

reaction is transmitted to the spinal ganglia. The reflex reaction is then carried from here to the spinal nuclei of the central gray matter, where the spinal centre of the sympathetic nerves is located. Here, the vaso-motor centres are finally impaired, and an impaired circulation in the corresponding vessels is thus brought about. Trophic changes are then the natural results of the disturbances described.

From what has been said above, the muscular atrophy can easily be accounted for. For the present, at least, there seems to be no explanation that is more acceptable. The subject of the various theories regarding the trophic changes does not enter into the scope of this work. It may only be remarked that Samuel's theory of the existence of special trophic nerves is not recognized to-day. The general tendency of the day is to ascribe to the vaso-motor nerves the major influence on the trophic changes. As these nerves run along the entire cerebro-spinal axis, they are subject to all the influences coming from the cerebrum or from the peripheral organs.

Experimental physiology has proven beyond any doubt the existence of vaso-motor reflexes. The sensory surface of the skin as well as that of the mucous membranes is continually bringing these reflexes into play; and the internal surfaces of the joints make no exception to this function. For, as is well known, these surfaces participate intimately in the function of the sense of position assumed by the body. Their relation with the tonicity and the nutrition of the muscles is, therefore, of prime importance. It is evident, consequently, that a grave lesion of the joint must necessarily be accompanied by corresponding reflex disturbances as well as by an impairment of the muscles involved.

We have seen above that Brown-Séquard attributed amyotrophia of articular origin to vaso-motor disturbances of angio-spastic nature. The author was led to make this assertion on account of the anemia found in the muscles and the emptiness of the vessels that supplied them. It is important, therefore, to determine whether the atrophy is due to dynamic conditions of the spinal motor cells or to a neuritic process.

It has been proven by histological researches that neither of these causes is exclusively responsible for the amyotrophia here considered. Indeed, we know that muscular atrophy caused by suspension of motion takes place at least three weeks after the beginning of the pathological condition (Ughetti, Stier). Early and rapid trophic changes like those found in amyotrophia of articular origin cannot be explained on any other basis than on that of profound and prolonged anemia of the muscles concerned.

I also feel justified in making the following conclusions:

1. Amyotrophy that follows shortly after the onset of an articular inflammation is of a reflex vaso-motor origin.
2. The reflex action is conveyed from the joints, through the sensory avenues, to the spinal ganglia, the vaso-motor trophic centres, the sympathetic ganglia and the vaso-motor nerves.
3. The muscular atrophy depends very probably on ischemia caused by prolonged vascular spasm.

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Original researches and other MSS. will be carefully considered, and if found unsuitable will be returned, if accompanied by stamped, self-addressed envelope. News items from Institutions will be given all space available.

Dr. Greshom H. Hill, Superintendent of the Iowa Hospital for the Insane, at Independence, quotes, in his report of that hospital, the editorial from the June number of 1901 of this Journal regarding the employment of women attendants for male patients in the hospitals for the insane. He seems to endorse the suggestion made in that editorial regarding the advisability of employing women attendants in the male wards. He concludes by saying: "The insane men of the future will be cared for by female attendants and nurses to a great extent. This method of management would progress more rapidly if the wards were appointed with this method in view and when the precedent is once established. Many of the duties in the male wards can be better performed at less expense by female attendants.

When the legislature provides separate quarters for attendants, this method of administration will be promoted."

DR. WILLIAM MABON has been appointed superintendent of Bellevue and Allied Hospitals. In addition to his duties as superintendent, Dr. Mabon will act as consulting physician to the Pavilion for the Insane of Bellevue Hospital.

Dr. Mabon has had an extensive experience as assistant physician at the Utica State Hospital for the Insane, and as superin-

tendent at the Willard and St. Lawrence State Hospitals for the Insane.

It is to be hoped that he may be enabled to work improvements in the Pavilion for the Insane at Bellevue Hospital.

HUGHES MEMORIAL TABLET.—According to the *Philadelphia Medical Journal*, Dec. 20, 1902, over \$433.00 have been contributed to the fund for the erection of a memorial to the late Dr. Daniel E. Hughes. The place where the memorial is to be erected has not been decided on. The new Hospital for the Insane at Philadelphia and the College of Physicians have both been suggested as suitable places.

A NEW CUBAN JOURNAL. *La Cultura Latina* is the name of the new journal. It is edited by Dr. F. F. Falco. The aim of the new publication is that of strengthening the mutual bonds of the Latin people. Among the contributors to the first number are Professor Tarde, of the College de France, Professor Lombroso, of Turin, Professor Lacassagne, of the University of Lyons, Professor Prins, of the University of Brussels, and many others.

The illustrations are handsome and the appearance of the volume is pleasing.

PUBLISHER'S NOTE.

The unavoidable absence from the country of the Editor of this Journal has delayed the issue of the last two numbers. Subscriptions will be set ahead accordingly.

NEWS NOTES FROM EUROPE.

The business and scientific administration of the hospitals for the insane is strictly divided in the Department of the Seine, France. One of the alienists in this Department states that this strict division of work for the insane does not exist in the other Departments. At the Villejuif Asylum specially designed bedsteads are used for patients undergoing bed-treatment or *alitement*. The model was designed by Dr. Toulouse some eight years ago, before the bed-treatment came into vogue. He had designed them at that time for the use of agitated patients in general. These beds are iron bedsteads, like ordinary beds in construction, having the

foot-board and head-board cut off. The patients experience no inconvenience from the absence of the parts of the bed that were always thought indispensable. Although the beds are kept off the walls, the pillows do not slip from under the patients' heads.

At this asylum, a laboratory has been established for the purpose of advancing the study of psychiatry, psychology and the allied sciences. This institution is called Ecole des Hautes Etudes. A regularly appointed staff has the responsibility of the school and any one who wishes to work there is welcomed by its Director, Dr. Ed. Toulouse.

Serumtherapy is systematically practiced at this asylum in Dr. Briand's wards. Attendants are specially trained to assist the physicians with this work and to do it themselves, when necessary. With the help of these attendants a large number of cases can be treated by this method. The sterilization of the serum is made at a temperature of 115 degrees C. The minimum dose injected is one pint of serum. Dr. Marie also employs this method of treatment in his wards.

Laboratories at the Ste. Anne Asylum.—With a population of some twelve hundred patients, this asylum probably has more laboratories than any other asylum in France. There are as many laboratories as there are physicians-in-chief. A new laboratory is in process of construction. It is to be Professor Joffroy's laboratory. It is a two story building situated near the building called "Clinique." The construction of the surgical pavilion cost one million francs. All the surgical cases are sent there for treatment from the various wards.

The method of cytodiagnosis is largely practiced in Professor Joffroy's wards. His chef de clinique, Dr. Mercier, has made numerous lumbar punctures and is an expert at this work.

Dr. Régis, of Bordeaux, is rapidly spreading the science of psychiatry among the general practitioners. At the St. André Hospital he has a special ward for the treatment of acute delirii setting in during the course of acute contagious and infectious diseases. He has invited his colleagues who practice general medicine to send him their patients who suddenly develop acute delirium. The material in these wards is highly instructive and large numbers of students take interest in the study of the cases from the standpoint of psychiatry. Another interesting feature in psychiatric work in Bordeaux is an out-door psychiatric clinic. Dr. Régis has charge of this clinic, where he lectures once a week and makes clinical demonstrations once a week. The clinic is always crowded with students. The largest number of students are from among the pupils of the Naval School.

COMMUNICATIONS.

DR. J. VAN DEVENTER, Director of the Meerenberg Hospital for the Insane, Holland, writes the following:

"The psychiatrists all the world over are realizing more and more that it is necessary to place the hospitals for the insane on a footing with the general hospitals, in so far as the nursing of the patients is concerned. The trained nurse is to-day an indispensable element in the general hospital, as she alone seems to be able to successfully meet the technical and other requirements in her field of work. In the hospitals for the insane, the need of the woman attendant or nurse for the patients of both sexes is becoming more and more apparent.

During my twenty-five years' experience as physician in hospitals for the insane I have come to the conclusion that insane men should, whenever possible, be attended by women nurses. This truth has been forced on me by personal experience. In 1879 (April 26th) I took charge of the Buiten Gasthuis, in Amsterdam. I found the nursing staff at that time in an undesirable condition. The main reason for this was the fact that the men and women who engaged to do the work did so by reason of sheer necessity, when they could not secure work elsewhere. This condition of affairs made me consider the question in the broadest possible light. I cheerfully impart the information to the reader that my wife gave me some valuable suggestions on this subject. After I had had some thorough consultations with her on this subject, I concluded that the only reasonable thing to do in this matter was to reorganize the staff by giving it proper training and by substituting women nurses for the men attendants in the wards for insane men.

This very change necessitated a higher standard of the nursing staff. This innovation was gradually instituted; the Sisters* were given graduating certificates after they had had training during a period of from one to three years.

This reorganization was instituted not only in the Buiten Gasthuis but also in the Binnen Gasthuis.

The reorganization was made on the general principle of nursing staff organizations. Thus, there was a matron who was responsible for the nursing staff in general, and a head nurse, in charge of her wards, was responsible for her respective nurses. The nurses

*The word "Sister" used here has no technical meaning. The nurses do not belong to any religious order, but Dr. van Deventer uses the term in deference to the nurses' calling.—ED.]

were principally women. All nurses, however, men and women, under her care, were responsible to her for their work.

In keeping with the Dutch ideas, it was considered improper for women to bathe male patients and to attend to some special work connected with the nursing of men. For this reason it was necessary to employ some men nurses.

After the fundamental part of the nursing work was reorganized, it was necessary to keep it under constant vigilance. In this manner the new system of nursing prospered gradually and soon became recognized in our hospitals for the insane.

The growth of this new system met with some opposition, however, as it was believed by some that the presence of women nurses in the wards for insane men was not desirable. Fortunately for the insane men this opposition proved to be groundless. Experience taught us that the most violent male patients could readily be controlled by the women nurses. The main help under these difficult conditions was tact on the part of the nurses.

The training of the nursing staff was done on the same principles as was that in the general hospitals.

In 1892, I became Director of the Meerenberg Asylum, and soon reorganized there the nursing staff as I did in the other asylums. The Medical Staff helped me along in this reorganization.

The task was not an easy one, as every psychiatrist can judge. The nursing staff was upset by the reorganization, and, besides, higher demands were made on its theoretical and practical knowledge.

A new Zuster Huis (Sisters' Home) was built to accommodate 148 nurses. The service was divided into day and night duty and many conditions were changed to suit the new requirements. January 1, 1902, the number of nurses was 180. Fifty-one of these nurses were employed on the male side. Besides these, there were also fifty-one male nurses.

From my experience I find that the properly trained woman nurse does justice to her work and benefits the patients by her presence in the wards. The woman nurse seems to find herself in her proper sphere in the domain of nursing. This is not true of the man nurse, even when he comes from a good class of people and has a good reputation.

A great difficulty with some of the attendants, both male and female, is that they look on the institution as a training school, from where they are to graduate. The diploma thus obtained is looked forward to as a means of making a living and of getting married.

From my experience I come to the following conclusions:

1. The Medical Superintendent should in every respect be the head of the institution and should be assisted by a matron.
2. Every asylum physician should have a head nurse who is responsible for the nursing on the ward.
3. The actual nursing should be entrusted to the female nurse as much as possible. In Holland, the male nurse cannot be entirely done away with.
4. In order to attach the male attendant to his work as much as possible he is required, on admission, to know some trade and he is entrusted with the supervision of the work that corresponds to his trade.
5. Practical as well as theoretical knowledge of nursing of the insane should be required of the nurses. In choosing a nurse for her ability one should bear in mind that physical strength is also a necessary requisite in her."

Meerenberg, Holland,

May, 23, 1902.

DR. J. MOREL, of the Government Hospital for Insane, at Mons, Belgium, writes the following:

Attendants and Nurses in hospitals for the insane.—I have been connected within the last thirty years with hospitals for the insane in Belgium and my experience has been the following: In most of our asylums for the insane the religious sisters act as attendants. Although their devotion to their work is commendable, the discharge of their professional duties cannot be perfect because they have a special objection to being taught the medical elements of nursing.

I have also had occasion to observe the marked difference that exists between the nursing by men attendants and women nurses. Although there are a considerable number of men attendants who deserve credit for their work, the work of the women nurses for the insane is incomparably more valuable. As early as 1894 I had occasion to advocate the employment of women nurses in hospitals for insane. I gave my views on this subject in an article entitled "L'Enseignement Professionnel des Gardiens dans les Asiles des Alienes." I pointed out in this article that the condition of the asylums cared for by women nurses was superior to those attended by male attendants. The woman nurse is particularly fitted for this work, not only because of her natural qualities in this direction, but also for the reason that she generally comes from a higher class than does her male professional peer. Thus, the woman nurse has the following qualities to recommend her in

preference to the male attendant: She comes of a better class, she has a better education, she is more intelligent and she understands better the sacredness of her task.

It is not difficult to foresee the universal employment of the woman nurse in the wards for insane men in the near future.

Dr. van Deventer, of the Meerenberg Asylum, Holland, has made successful experiments in this direction. In this asylum the insane men are nursed by women. The latter are excused from doing certain special work that is offensive to the moral conceptions of the community.

He first organized this service in the Meerenberg Asylum in 1892. He made his work advance gradually. Thus, one female nurse was put to do work in the male wards. In 1893, this number was increased to 13. In 1894, more women nurses were required and the number was increased to 25. The number was then progressively increased every year to 29, 39, 44, 49 and 50. The prudence in making the substitution of women nurses a gradual one is self-evident, and Dr. van Deventer deserves credit for this method. Besides this, credit is due him for the accomplishment of the long planned scheme and, above all, for the excellent results attained by the realization of that scheme.

The method of substituting female nurses for men attendants has been tried in some other European asylums, but I cannot recall their names at the present moment.

Dr. van Deventer took particular pains to train these nurses and to furnish them with diplomas after graduation from the training school. This step was of paramount importance. Not only did the nurse form a better opinion of herself, but she also inspired the patient with full confidence in her professional ability.

ASILE D'ALIENÉES DE L'ETAT,

Mons, Belgique.

April 8, 1902.

DR. MARIE, of the Villejuif Asylum for the Insane, writes:

"Dear Colleague:

The question you ask me in reference to the advisability of the employment of women nurses in the wards for insane men presents a double interest, as it has recently been the subject of discussion in our own country, at the Congress of Family Care for the Insane, held in Paris, September, 1901.

The delegates of some of our scientific societies made a special study of this question, during their visit to the Meerenberg Asylum, Holland. In discussing the subject of women nurses in the wards for insane men, M. Granier says: 'During the visit at

the Meerenberg Asylum, alienists from many countries beheld with much astonishment the scene of the women nurses attending the insane men. These nurses accompanied the insane men, talked to them on their walks and entertained them as Odette did Charles the VIth. Dr. van Deventer called these nurses Sisters by reason of a touching delicacy of sentiment. In reality these nurses do not belong to any catholic or protestant order. If they are not married, it is simply because they are young.

'At first Dr. van Deventer had great difficulty in finding the proper people to do the work required, as devotion cannot be bought,—it can be gotten only by showing its appreciation. The Directors of the Meerenberg Asylum studied this question most profoundly and finally obtained what was desired by using the proper means.

'Thus, a retreat fund has been established for the nurses' use. This fund assures the welfare of those nurses who work until old age prevents them from properly discharging their duties. There is a special vacation villa, where the nurses can spend their vacation days in the country. Another villa is destined for convalescent nurses, and finally there is a nurses' hospital pavilion.

'The Administration, on the other hand, which offers all these advantages, makes it obligatory for every applicant to spend a probationary period; during this period the nature and character of the aspiring nurse can be ascertained.

'There are still other advantages offered to the nurses. The Société Wilhelmine, founded in 1898, by the young Queen of Holland, aims to further the professional education of the nurses. The fundamental principles of this Society are practically copies of those of similar English organizations. The Society has 1,400 members and a fund of 50,000 francs. The membership fees and the income from the fund are used for expenditures.

'The young women who enter upon their duties bind themselves to undergo training for a period of three years. During this time they receive not only the professional training, but every facility is also given them to develop such personal talents as they may happen to possess. Thus, during our visit to Meerenberg, one of the nurses sang most skillfully a solo with grace and accomplishment before a very large audience.

'The most lasting impression I retain of the visit to the Meerenberg Asylum is the following: I saw there a frail looking young nurse who calmly performed her duties among a number of noisy and excited insane men. She betrayed neither fear nor disturbance of manner, making the patients feel that she was mistress of the situation.

'It is difficult to explain how a frail woman does these things. Without going into any inquiries regarding this subject, however, it is sufficient for us to learn the fact that she can do it. It is evident that nature has made her capable to do this work. If, therefore, this is a fact, why should we not let her do this work, for which she has a special calling?' "

Very cordially yours,

A. MARIE,

*Physician in Chief, Public Asylums of the Seine,
ex-Director, Family Care, Seine.*

INTERNATIONAL CONGRESS FOR FAMILY CARE FOR THE INSANE.

The congress was held at Antwerp, September 1—7, under the presidency of M. Van den Heuvel, Minister of Justice. Many countries were represented by official delegates. Professor Tamburini said that it was desirable to adopt the family care of the insane wherever practicable; a resolution was introduced to this effect and was unanimously passed. Many other resolutions were passed relating to the care of the insane; the following are some of the resolutions:

The work of the insane should be done under medical supervision.

The personnel of hospitals for the insane should receive adequate training. The medical staff should have charge of this training.

Every hospital for the insane should provide one physician for every hundred patients; the physician who has such a duty should not be allowed to attend to private practice.

It is desirable that every hospital for the insane be provided with a suitable laboratory.

Foreign indigent insane should be admitted and treated in hospitals for the insane; the various Governments concerned should have some understanding regarding the monetary expenses thus incurred.

Every community should provide for the care of the insane in the early stage of the disease. A special physician should be provided for every large district counting over fifty thousand inhabitants.

RUDOLPH VIRCHOW. The sentiment for the erection of some universal memorial to Virchow seems to be growing everywhere spontaneously. His work was replete with fruitful results and will ever be a colossal monument to his memory. Among his works the chief one is that entitled *Die Cellularpathologie*; his other works are not less expressive of his genius and untiring application. Besides his manifold occupations, he found time to edit one of the most valuable publications entitled in full *Archiv fuer pathologische Anatomie und Physiologie und fuer klinische Medicin*. He was one of the exceptional men of learning who, while worshiping at the shrine of science, did not disdain to take a vivid interest in the political events of the day. It is a well known fact that his political opponents forced him to leave his medical post in Berlin because he had declared himself to be a Democrat. This incident did not prevent him from making himself felt in the political life of his country. Some of his most distinguished political enemies were at the same time his greatest admirers. It is impossible to give any adequate idea of the great life of this great man. The world of science has lost in Virchow one of the greatest men of the century.

DR. HENRI DAGONET. The death of Dr. Dagonet removed from the scientific world, one of the oldest and yet most progressive of scholars. He was one of the oldest and distinguished alienists of France. He was professor of psychiatry at the University of Strasbourg and the author of a text-book on psychiatry which was translated into many languages. He also published a large number of contributions to the study of mental diseases and rendered innumerable services to the cause of the improvement of the welfare of the insane.

DR. JULES FALRET.—At a recent meeting of the Academy of Medicine of Paris, Dr. Magnan read the eulogy on Dr. Falret, who was one of the leading psychiatrists of France and who contributed a large number of valuable studies of mental diseases. His most important work may be said to be that treating of general paralysis. Besides having been a capable alienist he was well known as a generous benefactor and was highly esteemed by all who came in contact with him.

STUDIES OF THE PATHOLOGICAL ANATOMY AND THE PATHOGENESIS OF ACUTE PSYCHOSES WITH MENTAL CONFUSION.— DR. M. CAMIA reports the findings in acute psychoses not only in his own cases but also in those of

other clinicians who published the cases and the respective post-mortem examinations. The author himself has published twenty-one such cases; the number of cases published by others is about forty-eight. The pathological changes of all the organs were examined and the following are the conclusions of these investigations:

All the cases of acute psychoses with mental confusion are due to a condition of intoxication. Some of these cases did and some did not, present complications. The pathological alterations found were not marked. Here and there were found alterations of the chromatic substance of the nerve cells in the cerebro-spinal axis, slight fatty degeneration of the hepatic and renal cells and at times there was found an augmented nuclear proliferation in the vascular wall cells. These lesions correspond, however, to every variety of acute psychoses similar in their manifestations. Thus, delirium tremens does not differ in its essential traits from those characteristic of grave acute mental confusion. The most that can be said is that in delirium tremens the prominent features are the visual hallucinations and the motor phenomena expressed by tremors. Anatomically, the difference consists of the following: There is frequently, although not always, found a cellular or a cylinder-axis alteration in the long cerebro-spinal tracts; the pyramidal or other tracts may be involved; the direct cerebellar tract may also be affected. The explanation of this is not easy to find, except that it may be supposed that the alcoholic poison has a predilection for the cells of the long cerebro-spinal tracts. This supposition may be made on the ground that in alcoholism the peripheral nerves are generally affected along their course.

Pathology does not teach us what the nature of the infection is that causes the acute psychoses. Indeed, we know that although some pathological alterations are found in various organs after death due to acute psychoses with mental confusion, all these alterations may exist without giving rise to these psychoses, or else they may be found in cases of simple mental affections.

It would be wrong to say that a minor resisting power of the given individuals is responsible for the manifestation of the acute psychoses with mental confusion. As is well known, hereditary predisposition is minimal in these cases, while it is prevalent in the insane generally. Therefore we must admit that the above mentioned lesions are not characteristic of acute mental confusion; we must suppose, on the contrary, that there probably exists a factor unknown to us, which is closely connected with the causation of the disease and the visible pathological manifestations.

The action of intoxication as an agent in causing psychoses

may be likened to that of alcohol. The latter does not always produce the same affection in various subjects. In one it may cause delirium tremens, while in another it may cause uremia, etc. The same general clinical outlines are applicable to the action of intoxications.

In cases of acute psychoses following acute infectious fevers we must also apply the reasoning that impaired organic nutrition lies at the root of the trouble.

A third group to be considered is that of the true febrile delirii. This group may be subdivided into two varieties: one comprises the delirii manifested during the course of the febrile disease, and the other includes those caused by absorption of infectious matter, although true septicemia is absent. In either of these varieties it is difficult to indicate the moment and manner of infection.

Even in these infectious delirii, it is necessary to suppose the existence of some agent as yet unknown to us, which is responsible for the development of the delirium. Without this supposition the manifestation of the psychoses cannot be explained. The infection alone does not suffice as a determining agent, and the superposition of minor resisting power of the individuals, who have never before shown any psychiatric signs, is illogical as an explanation. Under these circumstances it may be supposed that the infection was most virulent.

The next group consists of cases in which no etiological factor could be pointed out. It is not easy to accept Bianchi and Peccinino's theory of the existence of a specific bacillus that is responsible for the manifestation of the psychoses. The authors who uphold this theory have not yet published a sufficiently large number of cases to prove the accuracy of their views.

According to Philippen, mental shock is due to a suddenly impaired organic metabolism due to disturbance of the nervous system.

Finally, it may be concluded that anatomical pathology does not explain the pathogenesis of psychoses with acute mental confusion. The only common manifestation in all mental affections is some impaired organic nutrition. This impairment may depend on various causes. *Rivista di Patología Nervosa e Mentale*, Vol. VII, fasc. 7.)

From the *American Journal of Insanity*, October, 1902:

1. THE MENTAL STATUS OF CZOLGOSZ, THE ASSASSIN OF PRESIDENT M'KINLEY.—DR. WALTER CHANNING has made a detailed investigation into the Czolgosz case, so far as he could, and says:

"It will be apparent from a careful perusal of what has already been said what conclusions I think I am justified in arriving at:

1st. I feel that from fuller information than that possessed by those experts who examined Czolgosz after his crime, the opinion then expressed by them cannot be accepted as the final one.

2d. Owing to lack of time it was impossible in the examination referred to, to investigate the early history of Czolgosz. Had this been done some of his statements would have been found to be inaccurate.

3d. He was not in my opinion an anarchist in the true sense of the word, and while anarchist doctrines may have inflamed his mind and been a factor in the crime, it was not the true cause or an adequate explanation.

4th. He had been in ill health for several years, changing from an industrious and apparently fairly normal young man into a sickly, unhealthy and abnormal one.

5th. While in this physical and mental condition of sickness and abnormality, it is probable that he conceived the idea of performing some great act for the benefit of the common and working people.

6th. This finally developed into a true delusion that it was his duty to kill the President, because he was an enemy of the people, and resulted in the assassination.

7th. His conduct after the crime was not inconsistent with insanity.

8th. His history for some years before the deed, the way in which it was committed and his actions afterwards furnish a good illustration of the typical regicide or magnicide as described by Régis.

9th. The post-mortem examination threw no light on his mental condition and would not invalidate the opinion that the existing delusion was the result of disturbed brain action.

10th. Finally, from the study of all the facts that have come to my attention, insanity appears to me the most reasonable and logical explanation of the crime."

2. THE NATURE AND PATHOLOGY OF MYOCLONUS-EPILEPSY. With Report of Cases. DRS. PIERCE CLARK AND T. P. PROUT: Myoclonus-epilepsy was first described by Friedrich, in 1881. It is now generally considered as an independent symptom-complex. The pathological lesions of essential myoclonus seem to be located in the cerebral cortex, where the lesions of the greater part of other convulsive diseases are being located. In essential myoclonus the third or the

pyramidal layer of cortical cells are diseased. The form of degeneration of the cells is similar to that found in the second layer of cortical cells of the epileptic brain. Some clinicians consider this disease as a variety or a form of epilepsy, Dide and Rabot termed it *petit mal moteur*. They think that the disease is essentially a form of epilepsy characterized by an incomplete convulsive manifestation and by the motor element only.

The convulsions in this disease are sharp, sudden in appearance, as if produced by an electric current; large masses of muscles are affected. The trunk is very frequently affected and the patient jerks his body antero-posteriorly and laterally with suddenness and violence. The face and the distal portions of the extremities are quite frequently involved. As a general rule, both sides of the body are affected alike, the right having the preference. The contractions are not usually synchronous, however, and may be more frequent and severe on one side than on the other. Usually the myoclonus begins in the muscles of one or of both upper extremities, then involves the lower extremities, chest, abdomen, neck and face, in the order named. The muscles about the eyes and mouth are, as a rule, the last to be affected, although the reverse is sometimes true. Such cases are reported by Unverricht, Homen and others. The tongue and diaphragm frequently suffer in all severe cases. On certain days the contractions are milder or severer. When fully developed, the disease causes extreme exhaustion and may cause death. Under sedative treatment myoclonus-epileptic patients may enjoy long periods of intermission. The bromide salts are the most beneficial sedative agents in this disease.

Delasiauve described some phenomena of this disease in 1858. The full symptom-complex was first described in a novel, in 1873, by Emile Gaboriau. The first medical description of the affection appeared in 1887; it was given by Homen. Descriptions by other neurologists then followed. In all, there are 57 cases on record, four of which were published by the authors.

The subjects afflicted with this disease present a complexus of symptoms proper both to myoclonus and epilepsy. According to some, degeneracy lies at the root of the affection. Among the tangible causes seem to be alcoholism, tuberculosis, epilepsy, insanity and chorea. The disease may also be directly transmissible. Melancholic-mania is a frequent accompaniment of the disease, especially after prolonged series of convulsions.

3. SYMPATHETIC INSANITY IN TWIN SISTERS—DR GEO. S. WALKER:

According to the testimony of the patients'

mother, they were all their lifetime intimately associated with each other and remarkably sympathetic each with the other. The bond of sympathy was singularly manifested in their sickness. If one became ill, the other sister was sure to fall sick with the same symptoms. As an evidence of this sympathy not being assumed, it was related that one had an attack of pneumonia, and in a day or two the other was similarly affected. Under ordinary circumstances this would have been considered a coincidence. This is only one of the many instances in which their peculiar sympathy was manifested.

Before the onset of the attack of insanity, both sisters seemed to be in perfectly good health. One of them left home to attend the marriage of a friend out of town. Without any premonitory symptoms, the patient was suddenly taken ill with mental excitation. She talked incessantly and incoherently, made wild gesticulations, used profane and obscene language, tore and broke everything within her reach. She was taken home to be treated there. After she had been nursed for about a week, her sister, who was out of town on a visit to friends, was telegraphed for. On her arrival, she was informed of what had happened to her sister and was asked to assist in the nursing. This the healthy sister immediately undertook to do. As soon as she beheld her insane sister, she became violently insane. She manifested her insanity in precisely the same manner as had her sister. Both sisters were taken to the Western State Hospital, Staunton, Va. They arrived in a deplorable condition, both exactly alike, with all the symptoms of violent acute mania.

As a precautionary measure, they were placed in different wards, so that they could not see each other. One did not know that the other was there. The period of violence continued for some time in both sisters and the remarkable fact is the similarity of the progress of their attacks.

It is difficult to explain why both sisters should have presented exactly the same form of insanity at the same time. The insanity of the second sister might be explained as being due to beholding her sister in a deplorable condition. It is not quite as easy to explain, however, why she manifested the disease in exactly the same form as did her sister.

The most remarkable features of this phenomenon were seen later on in the course of the disease. Although neither knew that the other was in the hospital, there was a remarkable similarity in the eventual course of their diseases. Thus, when one got better, the other was better at the same time. Both continued to improve and both became more rational. After a while both relapsed at the

same time. They were allowed to visit each other and they recognized each other, without realizing, however, their situations or objecting to their surroundings.

Subsequently, they both manifested relapses of the diseases, became violent and finally both became demented about the same time. They have both continued in the same condition ever since the onset of the dementia.

The author states that he has given an exact history of the cases.

4. SOME RESULTS AND POSSIBILITIES IN FAMILY CARE OF THE INSANE IN MASSACHUSETTS.—DR. OWEN COPP:

Family care of the insane was instituted in Massachusetts in 1885. This was the pioneer State in the undertaking in this country. During the first five years the movement progressed steadily, then it gradually declined during the following nine years; in 1900, a renewed progress was observed and it has been holding its own creditably ever since.

Financially, the family care of the insane is a trifle more expensive than is the hospital care, when the bare figures only are compared. Thus, the aggregate average weekly per capita cost amounts to \$3.41, for family care. The corresponding cost for hospital care is \$3.31. This represents a cost as figured by superintendents of five State hospitals and two independent asylums.

Besides, the kind of patients boarded in families are less expensive to maintain than are other cases which must be cared for in the hospitals.

A closer consideration of the question shows, however, that in the end, the family care is the less expensive of the two. Indeed, experience has shown that the patients maintained in families recover sufficiently to soon become self-supporting, whereas they are apt to become chronic incurable cases and helpless cases if kept from coming in contact with the outside world. It appears that 10.6 per cent. of the patients maintained in families became self-supporting after boarding during an average of two years and two months; the longest interval of such boarding on record is nine years and one month. The previous hospital residence of the respective patients averaged four years and ten months and, the longest period, twenty-four years and eleven months. 58.5 per cent. had lived continuously in institutions for two years or more before boarding; 37.7 per cent. of the patients who boarded out had lived in institutions for 5 years or more. Nine patients have reappeared in institutions. The total number of the cases here considered is 113.

It is evident therefore, that while the family care of the chronic insane seems to be at first sight more expensive than is the hospital care, the family care is in reality the more economical one. This becomes much more apparent when one adds the additional expense attached to hospital care. Indeed, besides the weekly expenditure of \$3.31 per capita there is a permanent weekly expenditure of 58 cents per capita of the State's permanent investment.

The author seems to be in favor of the family care, as in his experience he has seen many cases recover and become self-supporting under this care. These cases would otherwise have remained permanent hospital charges.

5. TENT LIFE FOR THE DEMENTED AND UNCLEANLY. DR. ARTHUR B. WRIGHT: The tent life for this class of patients proved to be a success in the Manhattan State Hospital for the Insane, on Ward's Island. Patients who had improved remarkably during the Summer under his treatment had retrograded during the Winter, when taken into the usual wards. It is proposed to open another camp in the Summer. Convalescents will also be afforded the opportunity of leading a camp life.

INFANTILE PARALYSIS; AN EPIDEMIC OF THIRTY-EIGHT CASES.—DR. CHARLES E. PAINTER: The cases occurred in Gloucester, Mass., in the summer of 1900, between the latter part of June and the first part of September. In point of space they were within a radius of four miles and most of them were in a comparatively narrow compass. Most neurologists agree that the disease is of an infectious and epidemic character. In the author's series of cases there were twenty-three males and nine females. The youngest was thirteen months old and the oldest was ten years of age. Twenty-one cases were three years old or younger; eight cases were two years old or younger and seven cases were seven years old or younger. No cases observed became entirely well, and only one died. This latter case was not included among the thirty-eight cases reported. (*The Boston Med. and Surgical Journal*, Dec. 11, 1902).

BOOK REVIEWS.

TRATTATO DI PSICHIATRIA AD USO DEI MEDICINE DEGLI STUDENTI. CON NUMEROSE FIGURE INTERCALATE NEL TESTO. PROF. LEONARDO BIANCHI, *Director Psychiatric and Neurological Clinic, Royal University, and Superintendent Hospital for Insane, Naples.* Vol. II. V.

Pasquale, Naples. The first volume of this work was analyzed in Volume I, No. 2, of this Journal. In the present, the second volume of his treatise on psychiatry, Professor Bianchi has come up to the expectations of the scientific world. The author shows an independence of construction and disregard of the accepted routine generally found in the "make-up" of a text book on psychiatry. He seems to be guided by reason rather than by rules. Thus, as was stated elsewhere in this Journal, the first volume of this work is devoted to anatomo-cerebral considerations relating to the study of psychiatry. The present volume is devoted to the study of the numerous questions of physiopathology connected with the study of psychiatry. So far as is possible, illustrations are given, representing laboratory experiments. The understanding of the complex problems is thus made easy even for students who are making their first steps in the science of psychiatry. Among other chapters are the following: Physio-pathology of perception, of attention, of memory, of emotions and sentiments and of the will-power. After the acquirement of a thorough understanding of these elements, the student is well prepared to deal with the problem of consciousness. And indeed, the last chapter deals with the question of consciousness in its relation to the study of psychiatry.

The general handling of the book is most practical, as the author bases his arguments on solid clinical facts, as becomes an accomplished psychiatrist of his standing.

Making his final remarks in the chapter on consciousness, he says, in part:

Considered in its entity, consciousness has for its substratum the function of the entire cerebral structure. It is logical to speak of so many component parts of consciousness. Thus, the motor zones, the sensory zones, for instance, enter as component parts into the formation of what constitutes consciousness. The frontal lobes control and coordinate the activities of the various zones. The potentiality of the personality is expressed by the quality of the coordination of the motor and sensory functions in their relation to the frontal function. The subordination of all the functions to the frontal function is most indicative of the personality.

When the function of the sensory sphere, in its relation to the functions of the other spheres, overrules, degeneracy is preeminently present. The hypothesis may be advanced that sleep depends on the rest of the frontal lobes. During sleep, therefore, the sensory zones perform their activity in an uncontrolled manner; that is to say, without being controlled in relation to reality. This condition takes place during dreams. Very probably, during the state of somnambulism, the function of the frontal lobes is sub-

ordinate to that of the sensory zones. The amnesia of the somnambulist is due, perhaps, to the awakening of the frontal function. As this function did not participate in the somnambulistic manifestation, it remains alien to what had taken place. A similar phenomenon takes place during dreams which are not remembered.

It may be said of hallucinations that they are due to the predominance of action of the sensory zones. Not only do the sensory functions escape the control of the frontal lobes, but the latter are even subjected to the control of the sensory spheres within the limits of mental life. The small circuits of human action (automaticism, instincts, ideo-motor and sensory-motor reflexes) are the more pervious the more the large circuits, passing through the frontal lobes and controlling the smaller ones, are obstructed. The rôle of the frontal lobes is self evident when one thinks of the vast importance of the inhibition or the direction of action by synthesis.

Indeed, we easily find impairment of mental life and function in cases that present defective frontal development. There, indeed, there exists a lack of harmony between the function of the sensory areas and that of the frontal region. Many forms of insanity express the existence of a violation of the law of coordination and subordination of the various cerebral functions. In cases of paranoia, obsessions and criminality, for instance, these facts are clearly illustrated.

The study of the clinical features of psychiatry is reseved for the third volume, which is already in press.

LES OBSESSIONS ET LES IMPULSIONS.—A. PITRES and E. REGIS. Octave Doin; Paris, 1902. This volume treats not only of the simple obsessions and impulses, but of all the obsessions and impulses met with in the domain of psychiatry. The characteristic trait of this volume is the marked erudition shown on every one of its pages. Considering the importance of the subject examined, this trait is most valuable. On reading this book one feels that every document having any bearing on the subject has been cited, abstracted or referred to. The views of the classic as well as those of the modern authors are all represented, and this volume of 434 pages may well be called a complete treatise on obsessions and impulses.

The merit of the work lies also in the method of treatment. It is handled concretely, systematically and clinically. Among some of the chapters are the following:

Historical sketch of obsessions and impulses, diffuse phobias, or panophobias, special phobias or monophobias. Obsessions,—

impulsive and hallucinatory. An instructive chapter is devoted to the means of defence against obsessions used by the sufferers. Obsessional reddening of the face is treated of at length from the physiopathological and the clinical standpoints. Many instructive cases are cited as illustrations. A long chapter is devoted to the etiology, course, duration, termination and the treatment of obsessions. The impulses are treated of at great length, as the subject requires a thorough understanding of these clinical manifestations. The various impulses are carefully examined in their clinical as well as in their medico-legal significance. An important chapter on legal medicine concludes this most interesting volume.

GENERAL PARESIS. PRACTICAL AND CLINICAL—
ROBERT HOWLAND CHASE, A. M., M. D., *Physician-in-Chief, Friends' Asylum for the Insane; Late Resident Physician State Hospital, Norristown, Pa.; Member of the American Medico-Psychological Association; Fellow of the College of Physicians*, Philadelphia. Illustrated. P. Blakiston's Sons and Co., Philadelphia, 1902. The work is preeminently clinical in nature. The author informs the reader in the preface that no attempt is made to settle disputed questions regarding the pathology of general paralysis. He simply gives the results of his personal experience with this disease; and his experience has been extensive, gathered during a period of twenty-five years' study of the insane in two of the largest hospitals for the insane in Pennsylvania,—the Norristown and Philadelphia Hospitals. A few chapters are devoted to the consideration of the three accepted stages of the disease. These preliminary considerations are followed by chapters dealing with the varieties of general paralysis. Among these forms are mentioned the following: Galloping, circular, melancholic and spinal; simple progressive dementia, juvenile form, paresis in woman and senile form. The chapters following are those dealing with the particular symptomatology of the disease. Finally, the work is concluded by a consideration of the differential diagnosis, the etiology, pathology and treatment of the affection. Numerous illustrations representing paretic patients are to be found in the text. The work consists of 291 pages, and its reading is certainly most profitable from a clinical point of view.

DIE SEELE DES KINDES NEBST KURZEM GRUNDRISS DER WEITEREN PSYCHISCHEN EVOLUTION.—
DR. J. A. SIKORSKY, *Professor of Psychiatry, St. Vladimir*

University, Kieff. Johann Ambrosius Barth, Leipzig, 1902. The author treats of his subject in the spirit of a true student. We can gather most instructive facts relating to the functional development of the brain, he tells us, by making a comparative study of the growing infant in its normal and abnormal conditions. Although this statement furnishes no new information, it is yet most interesting to follow the author as he develops this idea in his work. Many works have been written on the cerebral function in the adult man, but there is hardly sufficient attention given to the study of this function in the infant. Yet the psychic development of the infant and child presents an inexhaustible source of information regarding some psychic phases that are difficult to trace in the adult. Indeed, many instructive psychological facts can be gathered from a comparative study of the child's cerebral development and its corresponding mentality at different periods of its life.

The author demonstrates, for instance, that at birth, the child's brain is of a lower grade of development than is that of the lower animals. At birth, the child is absolutely helpless. It does not know its mother, it does not distinguish sounds, it cannot see, etc. The reason of this condition lies in the undeveloped brain substance. Flechsig's researches in this line are instructive, showing the immature condition of the brain at that age.

In order to trace systematically the cerebral development in its relation to cerebral function, the author divides the study of the child's life into five periods, as follows: 1, the child at birth; 2, the first three months of its life; 3, from the fourth to the tenth month; 4, the end of the first year and the beginning of the second year, and 5, from the second to the sixth year.

It is most interesting to follow with the author the sensory development of the child's life that precedes the mental development. The child's wrath and joy are both carried to the extreme, because the reasoning power is not yet developed. Its facial expressions are representative of its sensory life. This point is illustrated by two photographs of a child during anger and joy respectively. As might be expected, the facial expressions are extreme, because reason does not yet exercise any controlling influence. The lack of this influence also explains the child's frequent tears and cries. During this early period of life the brain undergoes marked daily fatigue. The life of the young being may be compared to that of an experimentor: the multiple new impressions that force themselves on its mind compel it to take an active part in its surroundings and to become an interpreter of its relation to these surroundings.

Consequently, during the first few months, or up to the first year, the child undergoes marked nervous strain. This is expressed by frequent cries. The latter should be properly interpreted and rest should be given in the form of sleep.

The volume consists of 80 pages and is quite valuable as a psychological sketch.

DE LA LESION ANATOMIQUE DE LA PARALYSIE GENERALE. THESE POUR LE DOCTORAT EN MEDECINE.

V. MAGNAN: This thesis is of particular interest to those who have watched the development of research in general paralysis. There are few diseases in the scale of mental science that have attracted as much attention and brought forth as much exercise of the scientific mind as has the study of general paralysis of the insane. A week hardly passes without our having some new contribution to the study of the lesions found in this disease. The number of physicians who have contributed to the study of the anatopathology of general paralysis is legion. One would expect, therefore, to find that marked progress has been made in the knowledge of the microscopy and clinical aspects of the disease, at least as compared with the knowledge of it some forty years ago. A perusal of this thesis that treats of the disease in question astonishes the reader by its complete exposé of the clinical as well as of the microscopical knowledge of general paralysis. This thesis was written in 1866, yet every fact known to-day about general paralysis is fully touched on here.

LE TROUBLES DU SOMMEIL DANS LES NEUROSES. THESE, BORDEAUX, 1902. —DR. MAURICE DAMELON. The epileptics have a heavy sleep. They do not dream during their sleep, but at times they have nightmares during which they often have painful visions of red. The hysterical subjects have a light sleep; their dreams are influenced by the occurrences of the day. The neurasthenic subjects do not sleep well, or at least, they almost always complain of lack of sleep. This insomnia is peculiar to itself and typical, the patient not knowing exactly whether or not he has slept during the preceding night. These patients seldom dream, yet they feel tired when waking up. In mixed cases the disturbance of sleep varies according to the predominating neurosis.

GESCHLECHT UND KRANKHEIT. —DR. P. J. MOEBIUS. Carl Marhold, Halle a. d. S., 1903. The author has made a detailed investigation into the question of the comparative lon-

gevity of life of man and woman as well as into the comparative resistance to disease of the two sexes. He concludes this study as follows:

1. Men have a lesser resisting power to disease because of their mode of life. Venereal diseases and alcoholism are the most potent factors in lessening their resisting power to disease and death.
2. There is no sufficient ground to think that the sex of woman makes her less liable to disease and longer lived.

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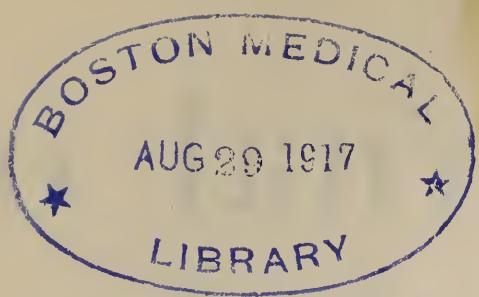
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